

National Cancer Waiting Times Monitoring Dataset Guidance

– Version 9.0

NHS England INFORMATION READER BOX

Directorate

Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy

Finance

Document Purpose Guidance

Document Name Cancer Waiting Times: A Guide (Version 9.0)

Author Cancer Waiting Times Team

Publication Date 30 October 2015

Target Audience NHS Cancer Service Managers and NHS Informatics Staff

Additional Circulation Cancer Network Directors and Information Leads

List

Description The document aims to provide answers to common questions about cancer waiting times requirements and seeks to ensure that staff from both informatic and clinical teams understand the cases they need to be reporting on.

Cross Reference N/A

Superseded Docs
(if applicable) Cancer Waiting Times: A Guide (Version 8.0)

Action Required N/A


Timing / Deadlines
(if applicable) **N/A**

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Document Status

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Owner	NHS England				
Version	9.0	Version Date	30 th October 2015	Status	Finalised
Author (Name/Position)	Jonathan Pearson, Analyst Kevin Doherty, Analytical Assistant				
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Approval Signature					
Version Approved	9.0				

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1 Introduction and Background

1.1 History of Cancer Waiting Times

Since the introduction of Cancer Waiting Times there have been a series of changes. '[The NHS Cancer Plan](#)', published in September 2000¹, contained a number of commitments and targets relating to waiting times for treatment. These included:

- Maximum two week wait from an urgent GP referral for suspected cancer to date first seen for all suspected cancers (collected from January 2001)
- Maximum one month wait from an urgent GP referral for suspected cancer to first treatment (start date) for acute leukaemia, testicular cancer and children's cancers (collected from January 2002)
- Maximum one month wait from diagnosis (date of decision to treat) to first treatment (start date) for breast cancer (collected from January 2002)
- Maximum two month wait from an urgent GP referral for suspected cancer to first treatment (start date) for breast cancer (collected from 2002)
- Maximum two month wait from an urgent GP referral for suspected cancer to first treatment (start date) for all cancers (collected from 2005)
- Maximum one month wait from diagnosis (decision to treat date) to first treatment (start date) for all cancers (collected from 2005)

The National Cancer Waiting Times Monitoring Data Set (NCWTMDS) was established to keep track of these standards and came into effect in January 2003. Previous to this the Quarterly Monitoring Cancer Waits (QMCW) central return collected the data required to monitor these standards. The introduction of the NCWTMDS is set out in the [DSC Notice 22/2002](#)². The equivalent changes required to the Data Dictionary are set out in the [DSC Notice 30/2002](#)³.

[The Cancer Reform Strategy \(CRS\)](#)⁴ was published in December 2007 and introduced new and changed commitments in terms of the service standards for cancer patients. The changes also aimed to align the Cancer Waiting Times collection with the 18 week referral to treatment (RTT) collection, the cancer registry and the national radiotherapy dataset.

The standards were updated to their current format in January 2009. The previous standards were adapted so that the start date was no longer from

¹ Document can be found in the national archives under the product number 22293

² Document can be found at <http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>

³ Document can be found at <http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/documents/dscn/dscn2002/302002.pdf>

⁴ Document can be found at <http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>

the cancer referral decision date by the GP (GMP, GDP or Optometrist) but the date which the provider receives the referral. Thus, before December 2008 the data collected was defined in a different way and should not be directly compared to the most recent data.

The new additional standards to be monitored were:

- A maximum two month wait from referral from a cancer screening service to first treatment for all cancers (collected from December 2008)
- A maximum two month wait from a consultant's decision to upgrade the urgency of a patient they suspect to have cancer to first treatment for all cancers (collected from December 2008)
- A maximum one month wait for all subsequent treatments for new cases of primary and recurrent cancer where an anti-cancer drug regimen or surgery is the chosen treatment modality (collected from December 2008)
- A maximum two week wait from referral for general breast symptoms (where cancer is not initially suspected) to date first seen (collected from December 2009)
- A maximum one month wait for all subsequent treatments for new cases of primary and recurrent cancer where radiotherapy is the chosen treatment modality (collected from December 2010)

This update to the standards is set out in the [DSC Notice 20/2008](#)⁵.

The Government's document '[Improving Outcomes: A Strategy for Cancer](#)'⁶ confirmed that cancer waiting times remain an important issue for cancer patients and that the NHS should continue to ensure that cancer services are delivered to patients in a timely manner.

1.2 Aims of document

This document aims to provide guidance and information about the Cancer Waiting Times standards and how to record the data in the National Cancer Waiting Times Monitoring Data Set. It will attempt to answer common questions about cancer waiting times standards and seeks to ensure that staff from both informatics and clinical teams understand the cases they need to be reporting on.

This document should be read in conjunction with [National Cancer Waiting Times User Manual](#)⁷ provided by the Health and Social Care Information Centre (HSCIC).

⁵ Document can be found at <http://systems.hscic.gov.uk/ssd/cancerwaiting/202008.pdf>

⁶ Document can be found at <http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>

⁷ Document can be found at <http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>

2 Standards

The cancer waiting times service standards are:

Maximum two weeks from:

- urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first outpatient attendance [**Operational Standard of 93%**]
- referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment [**Operational Standard of 93%**]

Maximum one month (31 days) from:

- decision to treat to first definitive treatment [**Operational Standard of 96%**]
- decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is
 - surgery [**Operational Standard of 94%**]
 - drug treatment [**Operational Standard of 98%**]
 - radiotherapy [**Operational Standard of 94%**]

Maximum two months (62 days) from:

- urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first treatment (62 day classic) [**Operational Standard of 85%**]
- urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment [**Operational Standard of 90%**]
- consultant upgrade of urgency of a referral to first treatment [**No Operational Standard as yet**]
- maximum one month (31 days) from urgent GP (GMP,GDP or Optometrist) referral to first treatment for acute leukaemia, testicular cancer and children's cancers [**No separate Operational Standard – Monitored within 62 day classic**].

It is not expected that all patients will be seen and treated within these time frames. Some patients will choose to wait longer and others will not be clinically fit to be seen/treated within these time frames. To take account of this, 'operational standards' have been set that allow for a proportion of patients to breach these standards due to medical reasons or choice. These operational standards are for all tumours taken together. Some tumour areas will exceed these standards; others (where there are complex diagnostic pathways and treatment decisions to make) are likely to be below these operational standards. However, when taking a typical provider's case mix as a whole, the operational standards should be achievable if providers have streamlined and efficient patient centred pathways in place.

2.1 Coverage of Standards

Cancer waiting times service standards are applicable to patients cared for under the NHS in England with [ICD](#) codes C00-C97 (excluding basal cell carcinoma) and D05 (All carcinoma in situ – breast). This includes those patients:

- being treated within a clinical trial
- whose cancer care is undertaken by a private provider on behalf of the NHS ie directly commissioned by an English NHS commissioner
- whose care is sub-contracted to another provider – including a private provider – (and hence paid for) by an English NHS provider ie commissioned by an English NHS commissioner but subcontracted out by the commissioned provider
- diagnosed with a second new cancer
- without microscopic verification of the tumour (ie histology or cytology) if the patient has been told they have cancer and/or have received treatment for cancer
- with any skin squamous cell carcinoma (SCC).

In terms of specific standards it should be noted that:

- the **two week wait standard** only applies to patients referred with a suspected cancer from a Clinical Assessment Service (CAS) (or walk-in centre) if the 'triage' GP or other health professional within the CAS (or walk-in centre) is acting on behalf of the patient's GP and locally agreed guidelines are in place that authorise them to act in this manner.
- the **one month (31 days) first and subsequent treatment standards** apply to:
 - NHS patients with a newly diagnosed invasive cancer (localised or metastatic), regardless of the route of referral
 - NHS patients with a recurrence of a previously diagnosed cancer, regardless of the route of referral
 - patients who choose initially to be seen privately but are then referred for first and/or subsequent treatments in the NHS.
- the **two months (62 days) standard** applies to patients who are referred:
 - through the two week wait referral route by their GP (GMP, GDP or Optometrist) with suspected cancer
 - urgently from any of the three NHS cancer screening programmes (breast, cervical or bowel)
 - then upgraded by a consultant (or authorised member of the consultant team as defined by local policy) because cancer is suspected
 - on suspicion of one cancer but are diagnosed with a different cancer.

In addition, patients who have been diagnosed with cancer after being referred by any relevant health professional because of breast symptoms (where cancer is not suspected) should be treated within 62 days. This is a recommendation, not a set standard, and therefore although data is collected on this pathway, this will not be performance managed centrally at the present time.

Cancer waiting times service standards are not applicable to patients

- with a non-invasive cancer ie:
 - carcinoma in situ (with the exception of breast (D05) which is included) – local systems will need to be in place to notify cancer registries of carcinoma in situ cases except for D05
 - basal cell carcinoma (BCC).
- who die prior to treatment commencing – local systems will need to be able to flag this and forward the information to cancer registries
- receiving diagnostic services and treatment privately. However:
 - where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the existing 31 day standards
 - where a patient is first seen under the two week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment, only the two week standard and 31 day standard apply. The patient is excluded from the 62 day standard as the diagnostic phase of the period has been carried out by the private sector.
- who refuse all reasonable offers of diagnostics or treatments, or opt to be treated outside of the NHS.

2.1.1 **What counts as a reasonable offer for diagnostics or treatments?**

For cancer waiting times a reasonable offer for diagnostics or treatments is counted as a service commissioned by an English NHS commissioner that is clinically appropriate as decided by the consultant.

2.1.2 **What is classed as a reasonable offer for the date of an appointment?**

For cancer waiting times a 'reasonable' offer of an appointment is defined by local policy and should be an offer for diagnosis or treatment in a cancer pathway.

Part of being reasonable means that the patient has been consulted and listened to, taking into account what the patient would find reasonable.

In cases of contention (such as treatments offered on the same day) the commissioner decides whether the offered appointment was reasonable.

2.2 Responsibility for Standards

The provider that is commissioned to deliver the activity ([DATE FIRST SEEN /TREATMENT START DATE \(CANCER\)](#)) is responsible for meeting the respective standard, for returning the data and for explaining breaches.

2.2.1 How are cases recorded where activity has been shared across more than one provider?

Some patients on the 62 day pathway are first seen at one provider and then referred on to another provider for treatment. In this case both providers share responsibility for ensuring that their respective parts of the dataset are uploaded and for ensuring that the 62 day waiting time service standard is met (See [Inter-Provider Transfer](#) and [Breaches](#) sections).

2.2.2 How do we record subcontracting?

If a secondary provider/outreach clinic/private provider is subcontracted for the patient activity by the commissioned NHS provider the activity should be recorded under the site code of the administrative headquarters of the commissioned NHS provider.

2.2.3 How are cases recorded where the initial activity has been completed at a screening service?

In some cases the initial activity (up to [DATE FIRST SEEN](#)) within a 62 day period (recorded as the cancer referral to treatment period – ie from receipt of the original referral to first treatment) is provided by a NHS Cancer Screening Service. In these cases the host provider for the screening service should provide the required activity and waiting times data up until [DATE FIRST SEEN](#).

Referrals are made to the assessment clinic within the screening host not to a specific consultant. In effect the screening centre is referring a patient to itself. Such clinics do not need to register to use the Cancer Waiting Times database (CWT-Db) in their own right as data entry would be carried out via the host provider of the screening service.

2.2.4 How are treatments tracked when the commissioner is the provider (eg when a GP or other primary care organisation has administered the treatment)?

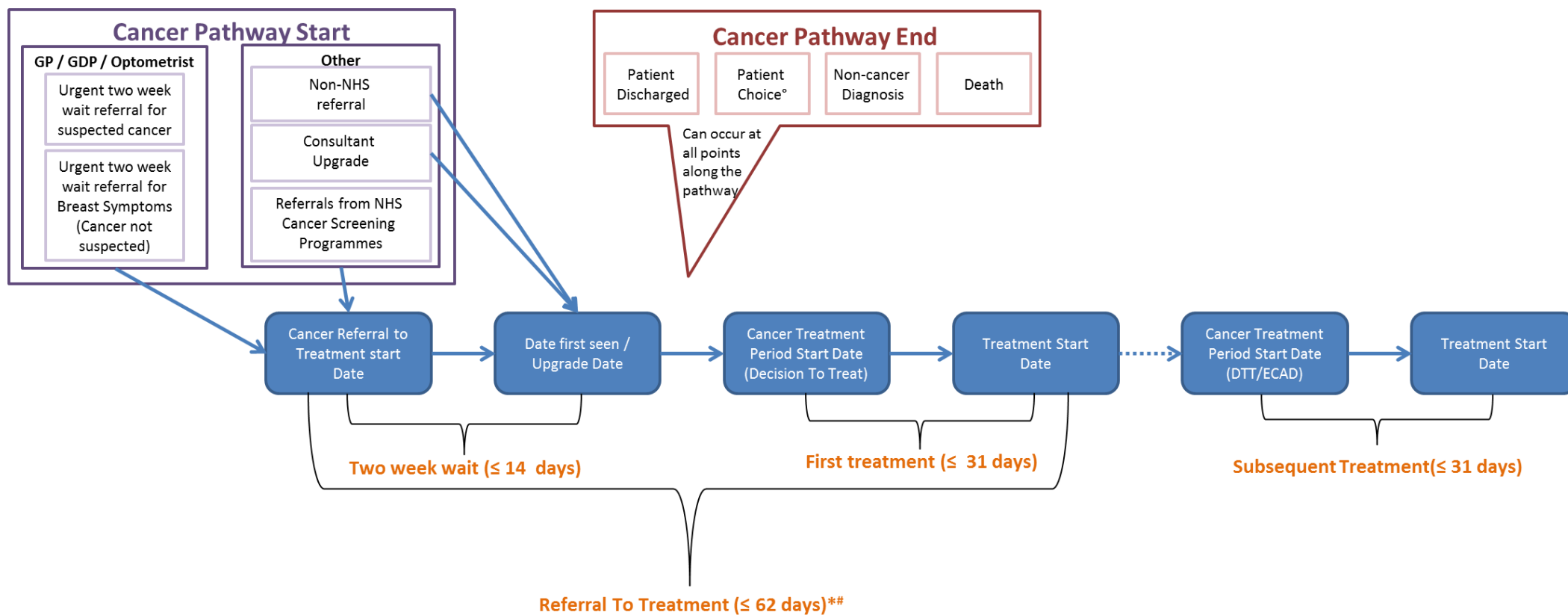
Primary care organisations are also responsible for providing data to be uploaded on to the CWT-Db to monitor the cancer waiting times service standards for cases where they are the service provider. However, it is not expected that GP (GMP, GDP or Optometrist) practices will register to be able to use the CWT-Db. Instead the commissioner will need to be registered as a provider on the CWT-Db to enable data to be uploaded by them on behalf of the primary care organisations. This needs to be arranged through the Open Exeter Helpdesk on 0300 303 4034.

2.2.5 How are drug treatments tracked as these are often administered externally to the provider?

When a drug treatment is prescribed the organisation that prescribed it records it. If the patient leaves the hospital with the prescription for the first batch of drugs and is to be supported for the remainder of course at the GP practice it is still the acute provider that should be reporting the treatment activity. If, however, the GP prescribes the treatment or the prescription is sent to the GP for action the commissioner should be recording the activity.

3 Key Dates

Figure 1 The Cancer Waiting Times Pathways



*The Consultant upgrade pathway starts at the Upgrade date, not the Cancer referral to treatment start date.

This standard is ≤ 31 days for rare cancers

° Patient Choice = Patient declining any further NHS treatment or investigation

Note: this diagram does not include recurrent cancers

3.1 Starting a pathway

The starting point for the two week wait is the receipt of the referral by the provider who will first see the patient (recorded as the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#)).

This original referral is received either:

- directly from the GP (GMP,GDP or Optometrist)
- via the NHS e-Referral Service, in which case the Unique Booking Reference Number (UBRN) conversion date for an appointment marks the start of the period; or
- via an alternative electronic system.

Referrals via post are not deemed good practice due to potential delays caused.

Receipt of referral is day zero.

Referrals received after a working day has finished should have the REFERRAL REQUEST RECEIVED DATE set as the date that the referral was received and not the next working day.

The 31-day pathway starts at the [CANCER TREATMENT PERIOD START DATE](#) which is also the DECISION TO TREAT (DTT) date. The DTT is the date the patient agrees a treatment plan.

3.2 Ending a pathway

The two week wait end point is either when:

- the patient is seen for the first time by a consultant (or member of their team) or in a diagnostic clinic following the referral receipt. This is recorded as [DATE FIRST SEEN](#)
- the patient is seen at a diagnostic clinic or goes 'straight to test' (unless that test is a blood test).

The 62-day and 31-day periods end at the first definitive treatment, recorded as the [TREATMENT START DATE \(CANCER\)](#). This is defined differently for different treatments.

3.2.1 Is information about the end point of a treatment required?

There is no central requirement to collect end of treatment or discharge dates for cancer treatment within the [CWT-Db](#), other datasets record this data.

3.2.2 What about cases which are given a negative diagnosis for cancer, a diagnosis of cancer not included in the [CWT](#) cohort or those which end their pathway before a diagnosis/treatment is given (ie patient choice to leave pathway or death of patient)?

For patients who have no diagnosis of cancer recorded and no subsequent 62 day period data is entered (ie after [DATE FIRST SEEN](#)) it will be taken that there was a non-cancer diagnosis. The activity up to the date first seen would still be counted and needs to be uploaded.

It is understood that you would want to close this record down locally. The data item [CANCER OR SYMPTOMATIC BREAST REFERRAL STATUS](#) supports local tracking. You could, for example, select Code 03 – ‘no new cancer diagnosis identified by Healthcare provider’. You can upload this data to the [CWT-Db](#) for completeness if you wish but if you do not the system will take it that the pathway ended at [DATE FIRST SEEN](#) ie the patients were not diagnosed with cancer and therefore did not continue on the 62 day pathway.

For cases where the patient dies before diagnosis/treatment, you would not upload records for this patient as a treatment did not take place – local systems will, however, need to be able to flag a patient death and forward this information to cancer registries.

3.2.3 How do we monitor a patient who refuses altogether the diagnostic test(s) that may diagnose cancer but continues to be cared for by the provider?

In effect the patient, by refusing the diagnostic test(s), has taken themselves off the 62 day pathway. The provider cannot deliver on a patient who is not prepared to "be on the pathway". This is recorded as Code 98 (all treatments declined) in the [CANCER TREATMENT MODALITY](#) field. This should only be used if all other [reasonable](#) diagnostic tests have been offered and so the patient is in effect refusing to be diagnosed within reasonable means.

If the patient agrees at a later stage to have the test(s) and is subsequently diagnosed with cancer, they can be monitored against the 31 day standard.

4 Referrals

The [DECISION TO REFER](#) date is the date on which:

- a GP (GMP,GDP or Optometrist) decides to refer a patient urgently to secondary care with suspected cancer; or
- any relevant health professional decides to make a referral to secondary care for breast symptoms (where cancer is not initially suspected).

This is not the date that starts the two week wait or 62 day clock. The clock starts from receipt of the referral ie the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#). The [DECISION TO REFER](#) is collected so that local analysis can be done on referral times.

4.1 Referral policy and guidance

Management of referrals between GPs (GMP, GDP or Optometrist) and secondary care is a matter for local protocol/policy within the overarching cancer waits rules.

- the best interest of the patient should be at the forefront of the local policy. Referrals between primary and secondary organisations should be monitored locally
- providers are encouraged to run daily checks for missing referral letters following an e-Referral Service referral, and follow these up with the relevant GP (GMP,GDP or Optometrist) practices
- the duty of care is with the referring practice. The practice will therefore need to have systems in place to ensure that referral letters are sent promptly and to ensure that patients they have referred convert their UBRNs in a timely way, where patients book their appointments directly through the e-referrals system
- for the two week wait referrals the required information should be sent to the receiving provider with one working day.

The patient should be encouraged to make an appointment quickly. There is a set of National Institute for Health and Care Excellence (NICE) guidance explaining what a patient should be told at <http://www.nice.org.uk/guidance/ng12>. If the NICE guidelines are followed it will hopefully encourage patients to accept the earliest appointment where possible. It would also be helpful for a GP (GMP, GDP or Optometrist) to reiterate the importance of keeping an appointment once it has been made.

For patients booking an appointment through the e-Referral Service (e-RS) it is stressed in the e-RS guidance that it is good practice to ensure the patient has booked an appointment before leaving the practice. It is also good practice to ensure that someone at the practice monitors, on a daily basis, the e-RS bookings to check that all Unique Booking Reference Numbers (UBRN) have been converted into a booking. For urgent two week wait appointments e-RS will only offer patients an appointment within the next 14 day period.

There should be agreed referral protocols in place between primary and secondary care so that GPs (GMP, GDP or Optometrist) know where to send patients. If they have sent a referral to the wrong provider that provider should liaise with the GP (GMP, GDP or Optometrist) and ask them to withdraw the referral and re-refer to a correct provider. This new referral would be recorded as the start of the two week wait. Alternatively, the wrong provider could forward the referral onto a correct provider if this is faster and in the patient's interest. In this case the two week wait clock would still be the original, wrong referral, from the GP (GMP, GDP or Optometrist).

Once the 62-day or 31-day clocks have started for a suspected cancer it is not expected that a patient would be referred back to their GP (GMP, GDP or Optometrist). Unless, cancer is ruled out or the management of the patient is being co-ordinated by the GP ie post anti-cancer treatment or hormones.

4.1.1 **What if the patient cannot attend an appointment within two weeks?**

If a patient cannot make themselves available for an appointment within two weeks, despite having been given appropriate information, it is technically possible for a GP (GMP, GDP or Optometrist) to defer making the referral until the patient is available for referral – a provider cannot refuse a referral.

Patients that choose an appointment outside of two weeks do not exempt themselves from the standards. The operational standards for the two week wait commitments take account of the volume of patients likely to be seen outside of two weeks due to patient choice.

4.1.2 **Can telephone triage stop the two week wait clock?**

The use of consultant or nurse lead triage of cancer patients is encouraged as this can lead to faster diagnosis. The use and process of a telephone triage is for local policy to decide.

However, the current cancer waits guidance is that the telephone triage will not stop the two week wait clock. This is because the two week wait pathway ends when the patient is “seen for the first time by a consultant (or member of their team) or in a diagnostic clinic following the referral receipt”. The key term here is seen and is required as there is a risk that a telephone triage may miss something that a face to face appointment would find as it is not a full assessment, but simply a way to ensure the patient has the right next step.

This piece of guidance is under review in consideration of making the diagnostic pathway more efficient and the use of new and future technologies.

4.1.3 **What about patients referred by a GP with special interest (GPwSI)?**

Only referrals from a GP (GMP, GDP or Optometrist) are included in the two week wait for suspected cancer cohort. If a GPwSI suspects cancer then there are two options:

- GPwSI advises the patient's GP to make an urgent two week wait referral

- GPwSI makes a referral which can then be upgraded onto the 62-day pathway.

Where a patient is referred by a GPwSI acting in their capacity as an ordinary GP code '03' should be used. Other health care professionals can only refer patients on the two week wait standard when a local policy is in place which allows them to act as the patients GP.

4.1.4 **How do we handle patients treated in England whose care was commissioned by a non English NHS commissioning body (eg Welsh local health boards or the Isle of Man)?**

All English NHS activity should be uploaded to Open Exeter, including any activity commissioned by non-English NHS commissioning bodies.

Patients whose care is commissioned by a non-NHS England commissioning body will be reported in the provider based statistics but removed from the commissioner based statistics automatically.

4.1.5 **What is the position of patients that do not reside in England but receive treatment from an English NHS provider?**

Anyone treated in England with an acceptable NHS number can have their record uploaded onto the CWT-Db. However, they may not be included in all outputs (e.g. reports) derived from the CWT-Db if their care was not commissioned by an English NHS commissioner. These patients are identified as being commissioned by an 'unknown' CCG in the CWT-Db outputs.

4.1.6 **What about patients referred for subsequent treatments after being diagnosed and treated in another country?**

Although additional tests may be required to confirm diagnosis, these patients should be recorded under the 31-day subsequent treatment target. The additional time taken for these patients is taken into account within the set operational standards. The [CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS](#) should be set to '13' for such cases.

4.2 **Referrals from NHS Cancer Screening Programmes**

Anyone suspected of having cancer during a screening appointment can have this suspicion forwarded to their GP who could initiate an urgent referral for suspected cancer. Receipt of this referral (the original referral request received date or the [UBRN](#) conversion if the e-Referral Service is used to make the appointment), is recorded as the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and would trigger the 62 day standard if cancer was diagnosed.

Breast, bowel and moderate or worse cervix patients would be [PRIORITY TYPE CODE](#) '2' referrals. Such referrals from the screening programmes are

automatically on a 62 day pathway until cancer is ruled out so an upgrade is not necessary.

If a patient comes from the cervical screening programme as a [PRIORITY TYPE CODE](#) '1' referral for low risk cervical cytology and cancer was then suspected they could be moved to the 62-day pathway through a consultant upgrade.

4.2.1 **When does the 62-day standard start for the three NHS cancer screening programmes?**

The clock start is the receipt of the referral (day 0) which for the individual screening programmes is as follows:

- breast - receipt of referral for further assessment (ie not back to routine recall)
- bowel - receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP)
- cervical - receipt of referral for an appointment at colposcopy clinic.

4.2.2 **What is recorded as the Date First Seen for screening cases?**

The [DATE FIRST SEEN](#) for the individual screening programmes are as follows:

- breast – first attendance for assessment in breast screening
- bowel – first appointment with specialist screening practitioner (SSP) to discuss suitability for colonoscopy
- cervical – first colposcopy appointment.

4.2.3 **When does the 62 day referral from a NHS cancer screening programme to treatment period end?**

If the patient is diagnosed with cancer the end point for this period is the first definitive treatment. This is recorded as the [TREATMENT START DATE \(CANCER\)](#). The treatment start date may differ slightly for different treatments. See [Treatment section](#) for further information.

If a reportable cancer diagnosis is ruled out the patient would either be discharged or continue on Referral To Treatment tracking if treatment for another (benign) condition is required – in this case the cancer referral to treatment period would end at [DATE FIRST SEEN](#).

4.2.4 **Who is responsible for uploading the screening part of the 62-day pathway?**

- breast – the provider commissioned to provide the screening service is responsible for uploading data on the first part of the pathway up to and including [DATE FIRST SEEN](#)
- bowel – the provider commissioned to provide the specialist screening practitioner (SSP) appointment to discuss suitability for colonoscopy is responsible for uploading data on the first part of the pathway up to and including [DATE FIRST SEEN](#)

- cervical – the provider commissioned to see the patient for their colposcopy appointment is responsible for uploading the data up to and including [DATE FIRST SEEN](#).

It is possible to distinguish between patients seen at a provider in its capacity as a screening host from those seen in its capacity as a conventional provider by the [SOURCE OF REFERRAL FOR OUTPATIENTS](#) data item within the patient record. If the provider is seeing a patient in its capacity as a host for the screening service the referral source would be code '17' which identifies it as a referral from a NHS cancer screening programme.

4.2.5 **Are patients on the 62 day screening standard covered by the two week wait standard?**

The two week standard does not apply to the 62 day screening patient cohort.

For screening referrals there is no national standard on time to [DATE FIRST SEEN](#) that is monitored centrally. There are, however, internal waits standards within the NHS cancer screening programmes. The relevant internal screening service standards are as follows:

- breast – a minimum standard of $\geq 90\%$ of patients attending an assessment centre within three weeks of attendance for the screening mammogram
- bowel – a specialist screening practitioner appointment should be offered within two weeks (14 calendar days) from the date that the faecal occult blood test (FOBT) kit was read
- cervical – at least 90% of women referred for colposcopy after one test reported as possible invasion or after one test reported as possible glandular neoplasia should be seen urgently within two weeks of referral
- cervical – at least 90% of women referred for colposcopy with a test result of moderate or severe dyskaryosis should be seen in a colposcopy clinic within four weeks of referral.

If these internal standards are met the vast majority of patients diagnosed with cancer via the NHS cancer screening programmes would be able to receive their first treatment within 62 days of the receipt of the referral if they were clinically fit and wanted to be treated within this timescale. The data items related to the two week wait standard (eg date first seen, relevant adjustment data etc) do, however, still need to be uploaded. For example, adjustments in the first part of the pathway may be relevant to the calculation of the 62 day period.

4.2.6 **Does the two week wait adjustment for “Did Not Attend” (DNA) of first out-patient appointments apply to patients who come via a screening route even though the two week wait standard does not apply to them?**

Even though patients coming through the NHS cancer screening programmes are not covered by the two week wait standard the adjustment for DNAing a

first out-patient appointment is included within the calculation of the 62 day referral to treatment period.

4.2.7 **Do screening services share breaches?**

The host provider commissioned to provide the screening service can share breaches with another provider involved in the 62 day period.

4.3 **Referrals from private practice**

4.3.1 **If a patient is referred via a two week wait then decides to be treated privately, how should this be managed?**

Only the part of the pathway covered by the two week wait referral needs to be submitted. These patients will be exempt from the 31 and 62 day targets.

4.3.2 **If a patient is referred via a two week wait, decides to have some or all diagnostic tests carried out privately, then returns to the NHS for treatment, how should this be managed?**

Only the part of the pathway covered by the two week wait referral needs to be submitted in the first instance.

When the patient returns to be treated in the NHS, the patient would be recorded on the 31 day pathway. These patients will be exempt from the 62 day target.

4.3.3 **If a patient is referred to the NHS from the private sector, how should this be managed?**

For these patients only the 31 day pathway needs to be submitted.

4.4 **Breast Screening Specifics**

4.4.1 **Should the first or second read of the mammogram trigger the referral for further assessment?**

The referral is triggered when the reader(s) decide to recall the patient for further assessment (rather than return them to routine recall) and that referral has been received. When the referral is made depends on the local protocol – the protocol could be to recall on the basis of one reader's recommendation or following consensus/arbitration.

4.5 **Bowel Screening Specifics**

4.5.1 **Is it the result of the Faecal Occult Blood (FOB) test or colonoscopy that triggers the referral from the bowel screening service?**

It is a positive FOB test result that triggers the referral (service request) from the screening hub and receipt of that referral by the screening centre for an

appointment with the specialist screening practitioner (SSP) that marks the start of the 62 day period.

The positive FOB test is an indicator of higher risk and ensures such patients are treated equitably with those referred with warning signs via the two week wait route. If a patient had to wait until the colonoscopy then they would almost be at the point of diagnosis when the 31 day standard would start which would gain little extra benefit for the patient.

A FOB kit will include six samples of faeces.

- a strong positive result is classed as five or more of the six samples including traces of blood
- a strong positive result would lead to an immediate referral
- a weak positive result (less than five samples including traces of blood) would lead to the test being repeated
- multiple weak positive results would lead to a referral
- a weak positive result followed by a negative result would lead to the test being repeated a third time
- if the third result is weak positive then this would lead to a referral
- if the third result is negative this would lead to a standard recall in two years.

4.5.2 **How are patients coming up to one year bowel screening surveillance managed under cancer waits?**

Patients under surveillance are having polyp management – they do not have cancer and are not expected to have cancer – they are on a preventative pathway so are not covered by the 62 day waits standard.

4.5.3 **Can the colonoscopy take place at a local provider's colonoscopy clinic rather than one within the NHS cancer screening programme?**

Only clinics accredited to the bowel screening programme can be used.

4.6 **Cervical Screening Specifics**

4.6.1 **Which abnormalities are included within this standard?**

All patients with moderate or worse cytology are included within the 62 day screening period. This includes the following cytology categories:

- possible invasive cancer
- possible glandular neoplasia
- severe dyskaryosis
- moderate dyskaryosis.

These referrals for colposcopy indicate at least cervical intraepithelial neoplasia (CIN) or a suspicion of cancer.

4.6.2 What are the referral priorities for different abnormalities?

Referrals direct from the cervical screening service should be identified as follows:

- moderate or worse cytology (ie abnormalities within the scope of the standard) – should be referred with a [PRIORITY TYPE CODE 2](#) (urgent)
- low risk cytology (ie abnormalities not covered by this standard – cancer not suspected/likely) – should be referred with a [PRIORITY TYPE CODE 1](#) (routine) and patients would be covered by the Referral To Treatment (RTT) pathway.

4.7 Referrals by Consultant Upgrade

If a consultant upgrades a patient for a first primary cancer the 62-Day period starts at the [CONSULTANT UPGRADE DATE](#). Only those upgrades that are diagnosed with cancer and go on to treatment need to be reported. The two week wait standard does not apply here.

4.7.1 Who can upgrade a patient?

A consultant or an authorised member of the consultant team (as defined by local policy) can upgrade a patient if cancer is suspected. The ultimate responsibility for upgrades rests with the consultant responsible for the care of the patient who will have delegated their authority by local agreement. The upgrades could come from any part of the health service not just from consultants and teams that most commonly see cancer patients. It is therefore important that local policies are agreed and processes are in place to publicise and operate the upgrade system locally.

4.7.2 Can there be an upgrade from any source of referral?

Yes, with the exception of:

- two week wait referrals for suspected cancer
- two week wait referrals for breast symptoms (not suspicious of cancer)
- urgent screening referrals.

These are exceptions because the patient would automatically be on a 62 day pathway if cancer was diagnosed.

4.7.3 Why not start this 62 day period from the receipt of the original referral which the consultant then went on to upgrade?

At the point when the original referral is received (recorded as the referral to treatment period start date or a RTT pathway) cancer is not suspected and it might be a few weeks before a consultant (or authorised member of a consultant team) decides to upgrade the patient onto a faster pathway. It is not appropriate to calculate a timed 62 day period from this point (ie retrospectively starting the clock from the original referral) as the patients was not on a faster pathway at that point.

4.7.4 If a patient is on a two week wait referral but is then admitted as an emergency, how is this recorded?

Where a two week wait patient is admitted as an emergency for the same condition (ie related to the suspected cancer) before they are seen they should no longer be recorded against the two week wait standard. The emergency admission is the referral into the system and supersedes the original referral. However, such a patient could be upgraded onto the 62 day pathway if a consultant or authorised member of their team suspects cancer is the cause of the admission.

Where a two week wait patient is admitted as an emergency for the same condition and a benign diagnosis is given for cancer whilst in the emergency clinic then the two week wait pathway finishes at the admission date and the patient would move onto a referral to treatment pathway if further care is required.

The cancer pathway is not affected if a patient is admitted as an emergency for a different condition.

4.7.5 Is it right that upgrades to the 62 day period cannot occur after the patient has been discussed at the Multidisciplinary Team (MDT) meeting?

An upgrade can occur after a MDT meeting as long as it was not the MDT meeting where the care plan that was agreed with the patient was discussed.

4.7.6 Is an upgrade possible if a recurrence is suspected?

No, the upgrade to the 62 day standard is intended for suspected new primaries only.

If a consultant (or an authorised member of the consultant team) wishes to upgrade a patient they suspect may have a recurrence it would be good practice for the locality to ensure the patient is diagnosed and receives their treatment as quickly as possible. Patients with suspected recurrent cancer will be covered by the 31 day standard for subsequent treatments if the recurrence is confirmed.

4.8 Symptomatic Breast Referrals

The difference between the urgent GP (GMP, GDP or Optometrist) two week wait referral and the symptomatic breast two week wait referral depends on whether the GP suspects cancer or not. Breast symptoms are defined for the purpose of this standard as any breast symptoms (covered in the NICE referral guidelines for suspected cancer <http://guidance.nice.org.uk/CG27>) that a healthcare professional believes need to be seen by a specialist, excluding referrals from family history clinics (unless a patient is symptomatic) or for cosmetic breast surgery.

These patients are tracked because approximately 50% of breast cancer patients do not come via the urgent two week wait route and 20% of breast cancers are discovered following non-urgent symptomatic referrals. Therefore it is recommended that these patients are fully tracked.

These referrals can be distinguished from suspected cancer two week wait referrals through the data item [TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE](#) where the breast symptomatic patients are given the code '16'.

Unlike the urgent GP (GMP, GDP or Optometrist) referral two week wait route, which can only have patients referred from a GP (GMP, GDP or Optometrist), the breast symptomatic two week wait route can have a source of referral from any of the following list, although not all of these would be expected to make such referrals.

- Emergency admission
- Referral following a domiciliary consultation
- Referral from an A&E department
- The consultant responsible for the consultant out-patient episode
- General medical practitioner
- General dental practitioner
- General practitioner with special interest
- Consultant, other than in an A & E department
- Self-referral
- Prosthetist
- Specialist nurse (secondary care)
- Allied health professional
- Optometrist
- Orthoptist
- Community dental service
- Other – not initiated by the consultant responsible for the consultant out-patient episode
- NHS cancer screening programme (only patients referred on the basis of exhibited symptoms (not screening results) with a priority type of '03')

4.8.1 If a patient is a two week wait symptomatic breast referral but is diagnosed with a different (ie non-breast) cancer would the patient stay on the 62 day pathway?

Yes. The patient should remain on a 62 day pathway.

4.8.2 Is it acceptable to allow direct GP referrals into radiology for symptomatic breast patients with the patient potentially referred directly back to the GP if the radiology is clear?

The breast cancer community has felt strongly for several years that direct GP access to mammography is not a good idea because GPs could (understandably) misinterpret the implication of a negative mammogram. The "triple assessment" (clinical examination, imaging and biopsy) approach at a breast centre is considered to be more reliable. This is one of the main

reasons for advocating a 'two weeks for all' approach for patients with breast symptoms.

4.9 Referrals for Recurrent and Multiple Primary Cancers

A GP (GMP, GDP or Optometrist) can make an urgent two week wait referral for a suspected recurrence or a suspected secondary new primary cancer.

- if the urgent two week wait referral is diagnosed as a recurrence they are covered by the 31 day subsequent treatment standard
- if the urgent two week wait referral is diagnosed as a new primary the patient moves onto the 62 day pathway.

The dataset includes a data item [CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS](#). One option to complete this field is 'diagnosis of a recurrent cancer'. Once this field is completed such patients would automatically be excluded from the 62 day standard by the [CWT-Db](#).

4.10 Referrals for Rare Cancers (acute leukaemia, testicular cancer and children's cancers)

Urgent GP (GMP, GDP or Optometrist) referrals for suspected rare cancers should result in a 31 day period (rather than a 62 day period) from receipt of referral if a patient is diagnosed with one of these three types of cancer. If a patient is not urgently referred but a consultant suspects one of these cancers they can upgrade. The upgrade would, however, be on to the 62 day period although we would recommend that you agree a local policy to treat such patients within 31 days if possible. Irrespective of your local policy you will be performance managed against the 62 day pathway, not the 31 day pathway, for patients upgraded by a consultant when one of these three cancers is suspected.

4.10.1 How is the 31 day rare cancer standard monitored?

31-day rare cancer patients are included within the numerator and denominator of the 62-day all cancer National Statistics published by NHS England. However, rare cancers are not included in the Open Exeter 62-day reports and so in order to get the full 62-day denominator from the Open Exeter reports a user will need to add the number of patients treated shown in the Open Exeter rare cancers report to the Open Exeter 62-day report. However, adding the numerators will not provide the correct figure because the reports are based on different standards.

These patients are separately reported by Open Exeter to enable your organisation to correctly manage these services and to ensure that all patients within the acute leukaemia, testicular cancer and children's cancers cohorts, who are fit and able and willing to be treated, receive that treatment within 31 days of the receipt of the initial referral into secondary care.

4.10.2 Is the accelerated 31 day measure (for acute leukaemia, testicular cancer and children's cancers) based on the suspected referral or the final diagnosis?

The 31-day referral to treatment measure (for acute leukaemia, testicular cancer and children's cancers) is defined by the PRIMARY DIAGNOSIS or the age of the patient at the point of the original urgent two week wait referral.

4.11 Inappropriate and Incorrect Referrals

Patients should not be referred back to their GP (GMP, GDP or Optometrist) because they are unable to accept an appointment within two weeks. Only the GP can downgrade a referral. If a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP.

- Patients should not be referred back to their GP after a single Did Not Attend (DNA) or cancellation
- Patients should only be referred back to their GP after multiple (two or more) DNAs but not after multiple appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

4.11.1 If the patient is not medically fit for diagnostics/treatment can the provider refer the patient back to their GP (GMP, GDP or Optometrist) to be re-referred at a later date?

This counts as a medical suspension and is not used in cancer waiting times. The operational standards for the 31 day and 62 day pathways takes this into account.

4.11.2 What if a patient is diagnosed with a different cancer to the one they were referred with?

Any patient urgently referred by their GP (GMP, GDP or Optometrist) with a suspected cancer and is then found to have a different cancer would stay on the 62-day pathway using the original receipt of referral for the wrongly suspected cancer up to the first definitive treatment for the new diagnosed cancer.

5 Diagnosis

5.1 Incidental Findings

Some patients may be diagnosed with cancer during routine investigations or while being treated for another condition ie incidental findings.

These patients should be monitored under the 31 day decision to treat (DTT) to treatment standard. Where the patient is treated immediately at the point of diagnosis the DTT will be the same date as the date of the admission (eg when a patient is incidentally found to have a cancer during surgery for a suspected benign condition).

If a patient is referred as a two week wait and a cancer is incidentally found that is unrelated to the referral, the 62 day period would end with the First Definitive Treatment (FDT) for the incidental cancer. Although the cancer diagnosis was incidental, it was found during investigations as part of the two week wait referral.

5.2 Multiple Diagnosis

If you are tracking a patient and they are diagnosed with two primary cancers each primary could have a different [PATIENT PATHWAY IDENTIFIER](#).

One would be generated at the point of referral and the other when the second primary is first suspected and the new (parallel) pathway starts. There would be one 62 day pathway linked to the initial urgent referral. The second cancer would be a 31 day pathway only (unless an upgrade takes place).

5.3 Diagnosis Uncertainty

If a two week wait patient cannot be given a formal non-malignant diagnosis and is followed up due to diagnostic uncertainty (eg at three monthly intervals), the patient remains on 62 day tracking until either a cancer diagnosis is made and treatment given or a non-malignant diagnosis is confirmed and the patient is discharged or continues on a [RTT](#) pathway.

The key is what the patient has been told.

If a cancer diagnosis has not been ruled out the clock would continue to tick until a diagnosis is confirmed.

From the patient's perspective the interval between being referred and diagnosis would clearly be greater than three months and the waiting time reported should reflect this.

A patient with diagnostic uncertainty is likely to have a longer than average diagnostic phase meaning that treatment will almost certainly be outside of 62 days and as such reported as a breach. This was taken into account when the operational standards were set.

6 Treatments

A treatment is:

“An intervention intended to manage the patient’s disease, condition or injury and to avoid further intervention. It is a matter of clinical judgement, in consultation with the patient.”

For cancer waits a first definitive treatment (FDT) is defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

6.1 Decision To Treat (DTT)

The DTT is the date the patient agrees a treatment plan. The date the patient signs the consent form may, depending on administrative procedures locally, take place some days after the DTT. It is advised that the meeting at which the treatment plan is agreed is classed as the DTT, not the date the consent form is signed.

6.1.1 Why does the 31 day standard start from the DTT rather than the diagnosis date?

In some cancers it is common for the diagnosis to take place after first treatment. For example, in testicular cancer, orchidectomy is counted as the [FDT](#), although a definitive diagnosis will not be obtained until after this operation has taken place. The start date for monitoring this standard needs to be the one that is meaningful for patients. The DTT date (recorded as the [CANCER TREATMENT PERIOD START DATE](#)) is the date of the discussion in which the patient and clinician (or authorised member of the team), agree the treatment plan for first (and/or subsequent) treatments.

6.1.2 Can a DTT date be changed?

Yes; if

- a patient decides they do not want the treatment originally agreed to (eg if a patient is offered surgery and is given a To Come In (TCI) date then decides they would rather have chemotherapy then the DTT is reset to when the chemotherapy is agreed); or
- due to clinical considerations after the agreement it is decided that the agreed treatment is no longer appropriate (eg pre-operative tests find complications); and
- a different treatment is discussed and agreed to, then the date of agreement for the treatment the patient goes on to have would be the new DTT and the 31-day clock is reset. Throughout all of this the 62-day clock continues.

6.1.3 If a patient's DTT is in the private sector but treatment is in the NHS (by the same clinician they were seeing privately), how do we record this patient?

As the clinician seeing the patient in private practice is the same one that will be treating the patient in the NHS it would not appear a good use of NHS time to have an additional consultation to agree the treatment again. However, as the DTT should be reached somewhere along the pathway of care the patient is following whilst in NHS commissioned care, the DTT in this scenario should be the point at which the English NHS provider commissioned to provide the treatment is notified that the patient is being transferred back into the NHS and that the clinician has already agreed with the patient the course of action.

6.1.4 When does the 31 day period start for a treatment that can only be provided following an application for funding to the commissioner?

The clock would start at the DTT for the treatment in question (recorded as the [CANCER TREATMENT PERIOD START DATE](#)). If an application then has to be made to the commissioner to approve funding of the treatment the 31 day clock has started and would not stop for the commissioner's decision making process ie the commissioner would need to ensure their processes are streamlined to manage the pathway for patients effectively, including hearing appeals etc.

6.1.5 If a commissioner declines to fund a specific treatment (and there is no appeal) would a new decision to treat for an alternative treatment and hence a new 31 day period be started?

The change of treatment would not be counted as part of the same 31 day period as that period did not end with a treatment. The 31 day clock would re-start once a new [DTT](#) date for an alternative treatment is made (this would be recorded as the [CANCER TREATMENT PERIOD START DATE](#)).

The clock for the 62 day period (if applicable) would continue until a treatment takes place (ie until there is a [TREATMENT START DATE \(CANCER\)](#)).

6.2 Transfer to Treatment Date

The transfer of patients between providers is called an Inter-Provider Transfer. The date when this occurs has in the past been ambiguous. In order to clarify this situation the [REFERRAL REQUEST RECEIVED DATE \(INTER-PROVIDER TRANSFER\)](#) data item will be introduced into [CWT-Db](#) in April 2016. This data item should only be populated for the last transfer in a patient's pathway; but the guidance behind it can be used for all Inter-Provider Transfers even though these will not be recorded in the data base.

The [REFERRAL REQUEST RECEIVED DATE \(INTER-PROVIDER TRANSFER\)](#) is populated with the same date that is already recorded under the same data item in the local patient administration service.

This is the date when the provider due to receive the patient receives the transfer request for the patient. This will not necessarily be the date when the patient files/records are received.

For any patient who during their cancer care sees two or more providers this field should be populated. If the patient goes to more than two providers this field is only populated with the last transfer to the provider starting the [FDT](#). Some example scenarios are shown:

Example 1: Patient referred to Provider A. The patient has their first outpatient appointment with a consultant, is diagnosed and treated at Provider A. The [REFERRAL REQUEST RECEIVED DATE \(INTER-PROVIDER TRANSFER\)](#) is left blank.

Example 2: Patient referred to Provider A. The patient has their first outpatient appointment with a consultant and is diagnosed at Provider A. A decision to refer the patient to Provider B is made on the 1st April. The referral request is sent on the 2nd April. Provider B receives the referral request on the 3rd April. The patient is admitted for treatment on the 7th April at Provider B. The patient is given a first definitive treatment on the 25th April at Provider B. The [REFERRAL REQUEST RECEIVED DATE \(INTER-PROVIDER TRANSFER\)](#) is recorded by Provider B as the 3rd April.

Example 3: Patient referred to Provider A. The patient has their first outpatient appointment at Provider A is then referred to Provider B. Provider B performs diagnostic tests before referring the patient back to Provider A. Provider A diagnoses the patient and refers them to Provider C. Provider C receives the referral request on the 3rd April. Provider C goes on to start a [FDT](#). The [REFERRAL REQUEST RECEIVED DATE \(INTER-PROVIDER TRANSFER\)](#) is recorded by Provider C as the 3rd April.

6.2.1 Who is responsible for completing this field?

The responsibility for completion of this field is with the provider starting the FDT. If the referring provider disagrees with the date the treating provider submits then they should contact the treating provider to see if there has been a mistake.

6.3 First Definitive Treatment (FDT)

The FDT is normally the first intervention which is intended to remove, debulk or shrink the tumour.

Where no definitive anti-cancer treatment is planned almost all patients will be offered a palliative intervention (eg stenting) or palliative care (eg pain relief), which should be recorded for these purposes.

6.3.1 **If a cancer treatment is unsuccessful is this still classed as a FDT?**

If a procedure is intended to be 'anti-cancer' but is unsuccessful, such as an open and close surgery where the tumour is not removed, then this is still classed as a FDT.

6.3.2 **If a patient is treated for a suspected cancer but during the treatment it is found that the patient has an entirely different cancer which has not been treated by the treatment, does the treatment count as a FDT?**

No, if a patient is treated for one suspected cancer but found to have a different cancer to that which was suspected (ie the original diagnosis was incorrect) and the original treatment was not able to treat the newly identified cancer, then the original treatment is not classed as a FDT. Even though the treatment had an anti-cancer intention it is more important that the patient is continued to be monitored to ensure they are re-diagnosed and treated as quickly as possible.

6.3.3 **Can diagnostic procedures be counted as a FDT?**

A diagnostic procedure, undertaken as therapeutic in intent (ie the intention is to remove the tumour), will count as a FDT irrespective of whether the margins were clear.

A purely diagnostic procedure (including biopsy) does not count as a FDT unless the tumour is effectively removed by the procedure. If the intention was diagnostic and the excised tissue was found to be malignant the procedure could count as a FDT if the tumour has effectively been removed by the excision.

6.4 **Enabling Treatments**

The enabling treatments that can be classed as [FDTs](#) are:

- colostomy for bowel obstruction
- insertion of oesophageal stent
- non-small cell lung cancer stent
- ureteric stenting for advanced cervical cancer
- insertion of a pancreatic stent if planned to resolve jaundice before the patient has a resection or starts chemotherapy
- Gastrojejunostomy
- Monofer Infusion
- Cystodiathermy

Other enabling treatments can only be used to end a pathway when a patient is to have X enabling treatment, is admitted for this and remains as an in-patient between the enabling treatment and the main anti-cancer treatment i.e. if they both take place within the same hospital provider spell then the date of admission ends the 62 day period even though the enabling treatment was given first within that spell.

6.4.1 **What do we do if we think an enabling treatment is being used differently to when the operational standard was set?**

In exceptional circumstances the cancer waits team might consider a particular enabling treatment again. Details would need to be sent to cancer-waits@dh.gsi.gov.uk setting out the procedure in question, what it is used for, how often and why its use has changed significantly since the publication of the current operational standards.

6.5 **Anti-Cancer Drug Regimen**

Cancer Treatment Modality

02 Anti-Cancer Drug Regimen (Cytotoxic Chemotherapy)

03 Anti-Cancer Drug Regimen (Hormone Therapy)

14 Anti-Cancer Drug Regimen (Other)

15 Anti-Cancer Drug Regimen (Immunotherapy)

6.5.1 **Under what circumstances are these first definitive treatments (FDT)?**

- chemotherapy (including prior to planned surgery/radiotherapy)
- biological therapy including treatments targeted against a specific molecular abnormality in the cancer cell (eg rituximab, trastuzumab, imatinib) and treatments which target the immune system (eg interferon, interleukin 2, BCG)
- Hormone treatments when:
 - given as the sole treatment modality
 - the treatment plan specifies that a second treatment modality should only be given after a planned interval (see [6.5.9](#) for further information).

It is not acceptable to use Hormone Therapy as a means to end a 62 day period if the initial choice of [FDT](#) is not available within the standard time due to capacity problems.

6.5.2 **Is each dose of chemotherapy classed as a different treatment?**

A course of chemotherapy is counted as a single treatment. A course could be comprised of a single dose or many cycles of doses.

6.5.3 **Would a change in drug type within chemotherapy be classed as a subsequent treatment?**

If you are modifying a regimen during the course of the chemotherapy then the same 31 day standard could apply if it was decided to make a change to a drug mix but the treatment was carrying on uninterrupted.
A change in drugs would be classed as a subsequent treatment if it was classed as a different course of chemotherapy.

The key should be whether a new consent form has been signed or not ie if it has then this should be classed as a new treatment and therefore a new 31 day period started.

6.5.4 How should biological therapies be coded?

This should be coded as '14 - anti-cancer drug regimen - other'.

6.5.5 How should thyroxine be coded?

This should be coded as '03 - anti-cancer drug (hormone)'.

6.5.6 What is the position regarding GPs/commissioners uploading data to CWT-Db for drug treatments?

When a drug treatment is prescribed, the organisation that prescribed it records it.

If the patient leaves the hospital with the prescription for the first batch of drugs and is to be supported for the remainder of course at the GP practice it is still the acute provider that should be reporting the treatment activity.

If the GP prescribes the treatment or the prescription is sent to the GP for action the commissioner should record the activity.

6.5.7 What is the date of the FDT if treatment is self-administered?

The [TREATMENT START DATE \(CANCER\)](#) should be recorded as the date of the outpatient appointment where the patient is given the prescription.

6.5.8 How should we record the use of supportive care drugs on the CWT-Db?

Supportive care drugs alone are not considered a [FDT](#) unless a patient is receiving palliative care only (of which these drugs are part) and no active treatment is planned.

6.5.9 Is hormone therapy recorded as a FDT when given at the same time as another treatment?

Hormone treatment can only be classed as FDT if it is to be the sole treatment modality or the treatment plan specifies that a second treatment modality should only be given after a planned interval.

Hormone treatment conducted at the same time as another modality would either be:

- neoadjuvant therapy – (therapy is necessary prior to treatment as specified by the care plan) in which case this would be counted as a FDT
- part of a combined treatment in which case a single treatment package is recorded (see [6.10](#)); or
- counted as a subsequent treatment, including adjuvant therapies (where the hormone is given after surgery to prevent recurrence).

6.6 Palliative Care and Active Monitoring

Specialist Palliative Care (SPC) is provided when no active treatment is planned via:

- hospital SPC teams
- community SPC teams.

[Cancer Treatment Modality](#)

07 Specialist Palliative Care

08 Active Monitoring (Excluding Non-Specialist Palliative Care)

09 Non-Specialist Palliative Care (Excluding Active Monitoring)

Also see section [6.10.1](#) regarding palliative treatment packages.

6.6.1 **What is the difference between Specialist Palliative Care (Code '07') and Non-Specialist Palliative Care (Code '09')?**

Specialist palliative care is delivered under the management of a consultant in palliative medicine.

Non-Specialist Palliative Care is any palliative care (excluding active monitoring) that is not given under the management of a consultant in palliative medicine.

6.6.2 **Are palliative treatments (surgery, radiotherapy or anti-cancer drug regimens) classed as palliative care?**

For cancer waiting times, palliative treatments (surgery, radiotherapy or anti-cancer drug regimens) should not be classed as palliative care generally. This should be classed as the relevant treatment (surgery, radiotherapy or anti-cancer drug regimens).

6.6.3 **How is care at a hospice recorded?**

For the purposes of cancer waiting times if a patient is transferred to a local voluntary hospice for palliative treatment and no active treatment is planned then the date of the referral to the hospice would count as the start date of the treatment. This would be recorded by the NHS organisation that made the decision to transfer the patient to the independent palliative care provider.

6.6.4 **Is specialist palliative care (SPC) in hospices excluded from cancer waiting times if carried out by a non-NHS provider?**

The [CWT-Db](#) is not able to capture data from non-NHS hospices as they do not have an N3 connection or an ODS (Organisation Data Service) site code and (most importantly) are not subject to [DSCN 20/2008](#)⁸. It is estimated that approximately 20% of patients diagnosed do not receive first treatment within an NHS provider for various reasons which include:

- the local SPC service being non-NHS
- the patient electing to follow private treatment options; or

⁸ Document can be found at: <http://systems.hscic.gov.uk/ssd/cancerwaiting/202008.pdf>

- the patient passing away before treatment can be administered.

However, there are some instances where these services should be recorded:

- if the voluntary provider is sub-contracted to provide the service by an English NHS organisation that has been commissioned to provide the care. In this case the commissioned organisation should report the activity, with the start date being the initial consultation (if available), or the referral to the voluntary service (if the consultation date is not available)
- if the service commissioned is a joint venture between an English NHS provider and a voluntary provider the activity should be recorded by the NHS provider with the start date being the initial consultation
- If the activity is commissioned from the voluntary sector by the NHS and the contract includes the requirement for the voluntary provider to provide the regular NHS datasets. In these instances we would have expected the voluntary organisation to have made arrangements to pass these data back to the commissioning authority for processing with the start date being the initial consultation
- if the consultant caring for the patient in the voluntary service is providing the service as outreach, the employing NHS organisation would record these statistics as per their normal practices.

Patients treated under these scenarios will be in the minority and most care in (provided by) voluntary organisations remain outside the scope of this data collection as it is not commissioned by the NHS.

6.6.5 **What is Active Monitoring and when can it be used?**

This is where a cancer diagnosis has been reached but it is not appropriate to give any active anti-cancer treatment at that point in time but an active treatment is still intended/may be required at a future date.

The decision to whether it is appropriate to give a treatment should only consider the diagnosed cancer and not patient thinking time (see [6.6.6](#)) or other medical conditions that the patient has (see [6.6.7](#)).

The patient is therefore monitored until a point in time when it is appropriate to give an active treatment for the diagnosed cancer. A patient would have to agree that they are choosing to be actively monitored for a period of time rather than receiving active cancer treatment. Active monitoring may be used for any tumour site if appropriate and it would start on the date of the consultation where this plan of care was agreed with the patient.

Whilst a patient is being actively monitored they may receive symptomatic support.

If a patient has active anti-cancer treatment planned, but has other comorbidities, as a result of the cancer, which need to be addressed before

the active cancer treatment can commence then active monitoring can be used. Examples include:

- dietetics support for malnourished patients
- respiratory support for those with breathing difficulties
- haematology input where patients are anaemic etc.

It is not acceptable to use active monitoring as a means to end a 62 day period if the initial choice of first definitive treatment is not available within the standard time due to capacity problem or patient choice.

6.6.6 Can active monitoring be used to allow a patient time to consider treatment options?

Active monitoring is not a substitute for patient 'thinking time'.

For example, if a prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options, this is not active monitoring. However, if a prostate patient has a tumour that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA etc this would be active monitoring.

6.6.7 If a decision is made to monitor the progress of a patient for a few months as cancer is suspected but still not confirmed can active monitoring be used?

No. For cancer waits active monitoring is only a legitimate treatment option for confirmed cancers. In this scenario the patient has not received a confirmed diagnosis of cancer so active monitoring would not be a treatment option. This scenario is one of diagnostic uncertainty. The 62 day period remains open and the patient will breach if cancer goes on to be confirmed. The operational standard for the 62 day standard has been set to take into account that patients will breach due to clinical reasons.

6.6.8 A patient is on the 62 day period and is diagnosed with another medical condition, unrelated to the cancer, which needs treating/resolving before cancer treatment can be given – can active monitoring be used for the cancer?

No, in this scenario active monitoring is not appropriate.

This would previously have been a medical suspension. We are now handling this differently. Instead of the clock being paused, the clock will continue and the patient will breach but the operational standard has allowed for a proportion of patients breaching as they are not clinically fit to be treated within the standard time.

For example: A patient with a confirmed cancer has a fall before an appointment to discuss treatment options. This results in an injury which would delay the start of any anti-cancer treatment. Active monitoring cannot be used; this is a medical delay which is taken into account by the operational standards.

6.6.9 **Can Active Monitoring be used as a subsequent treatment?**

Active monitoring can be a subsequent treatment, but you would only want to use it where the intention was for long term surveillance where the decision had been taken to monitor the progress of a specific condition.

This category of treatment would exclude any ongoing assessments to determine fitness for a subsequent treatment (as this would be prior to the setting of an Earliest Clinically Appropriate Date). It would also exclude routine follow-up, as this is not intended as a treatment.

6.7 **Radiotherapy**

[Cancer Treatment Modality](#)

04 Chemoradiotherapy

05 Teletherapy (Beam radiation excluding proton therapy)

06 Brachytherapy

13 Proton Therapy

6.7.1 **Under what circumstances is radiotherapy a first definitive treatment (FDT)?**

When used to treat either the primary site or to treat metastatic disease with an unknown primary.

6.8 **Surgery**

[Cancer Treatment Modality](#)

01 Surgery

6.8.1 **Under what circumstances is this a [FDT](#)?**

- complete excision of a tumour
- partial excision/debulking of a tumour (but not a biopsy for diagnostic or staging purposes unless it effectively removes the tumour even if margins are not clear)
- palliative surgical interventions where no active treatment is planned to follow (eg formation of a colostomy for a patient with an obstructing bowel cancer, insertion of an oesophageal stent or pleurodesis).

6.8.2 **What data should be recorded on patients admitted as an emergency prior to surgery now that the system validation has been changed to only allow [CANCER TREATMENT PERIOD START DATES](#) that are on or before [TREATMENT START DATE \(CANCER\)](#)?**

Some cancer patients are admitted as emergencies and remain as an inpatient until they receive treatment. As the date of admission is counted as

the TREATMENT START DATE (CANCER), for surgical interventions the following scenarios should be considered when reporting this activity:

- if a CANCER TREATMENT PERIOD START DATE was determined prior to the emergency admission, for the admitted period within which the surgical intervention took place, that date should be recorded on the Cancer Waiting Times Database in all instances
- if the surgical treatment being recorded is a [FDT \(CANCER TREATMENT EVENT TYPE 01 or 07\)](#) and a decision to admit date exists on the hospital Patient Administration System (PAS) and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the decision to admit date should be recorded as the CANCER TREATMENT PERIOD START DATE and will be on or before the TREATMENT START DATE (CANCER)
- if the surgical treatment being recorded is a FDT (CANCER TREATMENT EVENT TYPE 01 or 07) and no decision to admit date exists on the hospital PAS due to the emergency nature of the admission with the patient having no prior communication with the provider for this condition ie no decision to admit date exists on PAS, and the admission episode was for the condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be the same date as the TREATMENT START DATE (CANCER)
- if the surgical treatment being recorded is a first definitive treatment (CANCER TREATMENT EVENT TYPE 01 or 07) and the original admission was not for the specific condition that the TREATMENT START DATE (CANCER) relates to, then the CANCER TREATMENT PERIOD START DATE should be recorded as the same date as the TREATMENT START DATE (CANCER). This will provide the same output as was generated from the Cancer Waiting Times Database prior to the implementation of [DSCN 20/2008](#)⁹ as all negative waiting times were previously rounded to zero in the reports; or
- if the surgical treatment being recorded is not the first definitive treatment ([CANCER TREATMENT EVENT TYPE](#) is not 01 or 07) and an Earliest Clinically Appropriate Date (ECAD) is being used to populate the field [CANCER TREATMENT PERIOD START DATE](#), the CANCER TREATMENT PERIOD START DATE and the [TREATMENT START DATE \(CANCER\)](#) should be recorded as being the date of admission as it is assumed that the patient became fit for their next activity during the same hospital care spell.

⁹ Document can be found at: <http://systems.hscic.gov.uk/ssd/cancerwaiting/202008.pdf>

6.8.3 If a surgery is started and has to be abandoned because the patient becomes too ill to continue, could it still be counted as a first definitive treatment (FDT)?

If the surgery had commenced but it had to stop then yes it would still be the FDT. Although, if the patient is admitted for surgery and becomes ill prior to the surgery being carried out it is different. To be classed as the FDT the admission has to be for the episode of care that ended with the treatment that stopped the 31 day or 62 day period. If the patient did not get to the treatment because they were taken ill prior to having the agreed treatment then the clock would continue until the patient is able to be treated.

6.8.4 How should stenting and clearing a stent be recorded?

Stenting should be recorded as a form of surgery if the reason for its use is applicable for the 31 day standard.
Clearing a Stent is only classed as a treatment if it debulks the tumour.

6.8.5 Does a second excision/wide local excision count as a subsequent treatment even if no further tumour is found/margins are clear?

Yes, provided that the first excision was a form of treatment and not a biopsy for diagnostic purposes only.

6.8.6 If margins are clear but a surgeon decides to operate to extend the margins further is this classed as a subsequent treatment?

Yes.

6.9 Other Treatments

[Cancer Treatment Modality](#) = 23

6.9.1 How should treatments using new technologies be recorded?

If there is not an appropriate category for a new technology it should be recorded under [CANCER TREATMENT MODALITY](#) as Code 23 'Other Treatment'. If you are not sure about how a treatment using a new technology should be coded or if you are aware of new treatments coming on line that would need a new code in the future please contact cancer-waits@dh.gsi.gov.uk.

6.9.2 How are transplants handled for cancer waits?

When the agreed treatment for a cancer is a transplant the [DTI](#) would be when the patient agrees to the care plan that includes the transplant.
The [TREATMENT START DATE \(CANCER\)](#) would be the date the patient is added to the transplant list.

For the purposes of monitoring the 62-day standards a transplant should only be considered first treatment if no other active anti-cancer treatment is given in the interim.

- for cancer waiting times both bone marrow stem cell transplants and peripheral blood stem cells are treated the same.
- it is a clinical decision whether to record bone marrow/stem cell transplants as 'surgery' or 'other'.
- cancer waiting times does not distinguish between whether the donor is allogeneic or autologous.

6.10 Combined Treatments and Treatment Packages

For the purposes of the cancer waits dataset combined treatments are treatments of different modalities combined in a way that they must be scheduled to take place together. These should be regarded as single treatment packages.

Examples of combined treatments include:

- chemoradiotherapy - where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective (eg weekly 5FU during radiotherapy for rectal cancer, radiotherapy given synchronously with cycle 4 of CMF for breast cancer)
- pre-operative or intra-operative radiotherapy - where radiotherapy is given just before or during surgery to maximise the effect of both treatments.

The definition of combined treatments excludes adjuvant therapies where each treatment can be scheduled separately. (eg breast surgery followed by post-operative radiotherapy, chemotherapy for small cell lung cancer followed by consolidation radiotherapy).

6.10.1 How are individual supportive care packages recorded?

For the purposes of monitoring the 31-day subsequent treatment standards, supportive care packages (palliation of symptoms, symptomatic support etc) are to be considered as the whole. This means that whilst a patient may be receiving a range of care (transfusions, pain relief etc), if it is a single agreed package, the start of the package of care should be taken as:

- the date of the delivery of the first episode
- the consultation that results in the referral to a non-NHS specialist palliative care service (that are not contractually obliged to return these data independently – see [6.6](#)); or
- the consultation at which the patient receives a prescription.

The recording of NHS supportive care provision will remain the responsibility of the organisation commissioned to provide that care unless there is a local agreement in place for this activity to be recorded by another organisation. However, it is possible that additional palliative care/support might be agreed after or in addition to this package which would count as a new 31 day period.

6.11 Treating Metastatic Disease

Treatment of metastatic disease is almost always classed as a subsequent treatment.

The exception is treatment of metastatic disease with an unknown primary where both first and subsequent treatments can be recorded. If originally the primary is unknown, but then at a date after the metastatic disease has had a [FDT](#) the primary is diagnosed, then the treatment of the primary would be recorded as a subsequent treatment.

If a new primary cancer is diagnosed with a metastatic disease and the metastatic disease is treated first then the treatment of the metastatic disease would be a subsequent treatment and uploaded as such. It does not matter that sequentially it took place before treatment of the primary in terms of the [CWT-Db](#) ie you do not need to upload the treatment records sequentially. The 62 day clock would not stop at treatment of the metastatic disease as this is not treating the primary cancer. The 62 day standard is for new primaries only not a recurrence or metastatic disease. You would upload the treatment for the primary as normal once it had taken place and this would stop the 62 day clock.

Metastatic disease details cannot be included on the record for the FDT of a known primary because if metastatic details were included it would not be clear if the treatment being reported on the CWT-Db was for the first treatment of the primary or for the treatment of the metastases.

6.12 Subsequent Treatments & Earliest Clinically Appropriate Date (ECAD)

All subsequent treatments for primary and recurrent cancer need to have a 31 day period recorded.

A subsequent treatment could be:

- anti-cancer treatment (curative or palliative) aimed at shrinking (or delaying the growth/spread) of the tumour/cancer
- the provision of palliation for the symptoms resulting from the tumour/cancer
- symptomatic support by non-specialist palliative care teams where no active cancer treatment is planned
- active monitoring (where no active or palliative treatment is appropriate).

An individual patient may receive one or a combination of these interventions

The 31 day subsequent treatment standards do not cover follow on treatments that are not directly related to shrinking or delaying growth/spread

of the cancer (eg closure of stomas, reconstructive surgery following initial surgery, rehabilitative and psychological services etc).

Subsequent treatments act in a similar way to the first treatment recorded under the 31-day standard. However, subsequent treatments can either start with a Decision To Treat (DTT) date or the ECAD.

The ECAD is the earliest date that it is clinically appropriate for the next activity that actively progresses a patient along the pathway for that treatment to take place. This should be a previously agreed and clinically appropriate period of delay before the next treatment can commence. The activity may not always be the start of the treatment itself but could be the next appointment which deals with the planning of that treatment. When determining an ECAD only patient issues should be considered, not local capacity constraints. The patient must be fully informed and agree to the ECAD.

The member of the consultant team liaising with the patient about the treatment in question would set the ECAD.

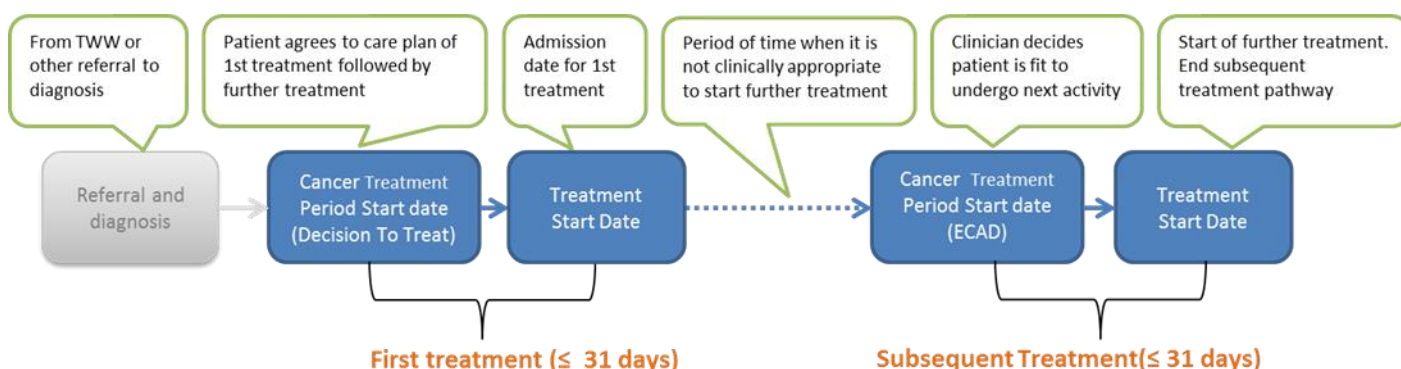
The ECAD can be with or without the presence of the patient and set at a number of points:

- at the clinical review with the patient following the preceding treatment. If it is not possible to make a decision at the review a further review could be arranged
- at the start of the preceding treatment if the patient will not be reviewed between treatments
- at the Multidisciplinary Team (MDT) meeting if it is possible to identify the likely ECADs between treatments in an agreed package
- following receipt of test results and prior to discussing with the patient if this is an appropriate date.

The patient does not have to be physically present on the date the ECAD is set as it can be set based on an earlier consultation.

The ECAD can be reviewed and changed any time up to the ECAD.

Figure 2 ECAD (patient not required to be present on ECAD date)



6.12.1 What counts as an activity in the context of an ECAD?

In the NHS Data Dictionary activity is defined as “A provision of services to a patient by one or more care professionals”. The ECAD relates to the next activity that actively progresses a patient pathway but not to an activity that relates to determining a patient’s fitness to continue their care plan.

6.12.2 Do subsequent treatments have to be uploaded sequentially?

Subsequent treatments are individual 31 day periods. It is therefore possible to upload details for a 31 day subsequent treatment period even if the details for the first treatment or previous subsequent treatment periods have not been entered onto the [CWT-Db](#).

6.12.3 Do subsequent treatments have to be linked back to the initial referral (which could be years back, especially for a recurrence)?

No, each subsequent treatment will be a new 31 day period starting at the [DTI](#) or [ECAD](#). The cases could be linked by the NHS number locally, if desired, for audit or trend analysis but this is not an automatic link and is not required nationally.

6.12.4 How long should patient records be kept open to take into account possible recurrences and therefore the need for subsequent treatments in the future?

Indefinitely, records are not closed. There can be multiple 31 day periods over a number of years, each starting with a new [DTI](#) date or an [ECAD](#).

A process needs to be in place locally to ensure that patients needing a subsequent treatment are identified and tracking restarts. Different models may be needed to capture information on patients with different cancer types and/or requiring different modalities of treatment.

6.12.5 How do you manage patients who receive an initial treatment from a private provider but then seek subsequent treatments through English NHS providers?

You need to have processes in place to identify and track any patient having subsequent treatments commissioned by English NHS providers, irrespective of whether earlier treatments were carried out by private providers. If a patient had a [FDI](#) in the private sector and then returns to the NHS for further treatment these further treatments would be classified as subsequent treatments (even if it is the first one they had on returning to the NHS).

6.13 Managing Recurrences

When a patient, who has previously had cancer has a recurrent cancer diagnosis confirmed, the patient would proceed onto a 31day subsequent treatment pathway.

The dataset includes a data item [CANCER OR SYMPTOMATIC BREAST REFERRAL STATUS](#). One option to complete this field is 'Diagnosis of a recurrent cancer'. Once this field is completed such patients would automatically be excluded from 62 day standard by the [CWT-Db](#).

If the cancer diagnosed was in the same location or was the same type of cancer as a previously diagnosed cancer but the cancer is classed by the clinician as a new primary then this would be a new 62-day pathway, not a recurrence eg if a patient has left breast cancer and then comes back at a later date with right breast cancer then which pathway the patient is recorded under is dependent on the clinical decision as to whether this is a new primary or not.

6.13.1 Is there a time period after which a recurrence would actually be classed as a new primary?

There is no time limit. A recurrence is a recurrence, not a new primary, if that is the clinical diagnosis.

6.13.2 What is the difference between recurrences (potentially cured but recurs in the future) and progression (not cured and will progress at some point) in terms of the cancer waiting times standards?

A recurrence is where a patient has previously been informed that they are free of the disease.

A relapse or progression of a disease is where this has not happened.

Relapse and progression are terms more commonly associated with non-solid tumours (eg haematological malignancies) where it is more difficult to clearly identify if a neoplasm has been eradicated.

It is a clinical decision which category is most appropriate and in terms of cancer waits, it is used for the [CANCER TREATMENT EVENT TYPE](#) data items.

6.13.3 How will the patient pathway identifier work for recurrences?

The identifier for the primary cancer would be used for any recurrence of the same primary cancer in the future. This is because a recurrence is a continuation of the same patient pathway and a patient pathway lasts for the entire period of a single disease/condition ie from the original referral request received date until a patient is cured or passes away. Even if a patient is discharged and then returns with a recurrence of the original condition, the identifier would be the same.

If a patient is diagnosed with a second primary cancer (ie not a recurrence of a cancer) this would have a new patient pathway identifier.

6.13.4 How is transformation of benign and/or cancerous cells dealt with in CWT?

For cancer waits,

- if the initial condition had been within the remit of cancer waits and transforms then it would be classed as a recurrence

- if the initial condition was not within the remit of cancer waits and then transforms the new condition would be classed as a new primary
- if the initial condition had not been given a diagnosis but was being kept under surveillance and later transforms into a cancer within the remit of cancer waits this would be classed as being on the original 62 day pathway.

For example:

- follicular lymphoma transforming into a diffuse large B cell lymphoma or AML transforming to CML or CLL transforming to Hodgkin's - would be classed as a recurrence as the initial conditions in each case had been covered by the cancer waits standards
- myeloid dysplastic syndrome transforming into AML - the AML would be classed as a new primary as MDS is not within the scope of cancer waits.

6.14 Trials

If a patient has agreed to enter a national portfolio clinical trial (a National Institute for Health Research trial) then the trial protocol will determine which treatments are classed as first or subsequent treatments respectively and they will be assigned as such under cancer waits standards. For example:

- if the trial protocol sets out that the first treatment could potentially be surgery, hormonal drug treatment or a placebo depending on the arm of the trial the patient was on it would not matter which of these treatments the patient received it would be classed as the [FDI](#)
- a second treatment could then be drug x or y or a placebo, it would not matter which of these treatments the patient received; it would be classed as a subsequent treatment.

Patients should be made aware if there is a possibility they may receive a placebo as part of their treatment within a clinical trial.

The [CANCER TREATMENT MODALITY](#) for a placebo would be classed as Code 14 'anti-cancer drug regimen (other)' for cancer waits reporting purposes assuming it is known which patient had received the placebo instead of another type of anti-cancer drug regimen. If it is a blind trial, and it is not possible to identify which patient received which type of drug, then the 'anti-cancer drug regimen (other)' category would be used for each drug arm.

7 Adjustments

Instead of a system of retrospective adjustments, which is time-consuming and difficult to justify to patients, we have a transparent system that gives a more accurate reflection of how long a patient has waited. It is recognised that for some patients the standard times will be inconvenient or clinically inappropriate. This relates to the following three types of patients:

- those who choose not to accept earliest offered appointments along their pathway or choose to delay treatment ie patient choice
- those who do not attend appointments along their pathway
- those with clinically complex conditions and/or co-morbidities unsuitable to be seen/treated within the standard time ie clinical exceptions/medically unfit.

These three categories of patients are being dealt with by a combination of adjustments and operational standards. Adjustments are used to reflect some elements of patient choice (ie [DNA](#)ing the first out-patient appointment or declining a reasonable appointment for admitted treatment).

All other elements, including clinical exceptions and patient thinking time, are taken into account by the operational standards which have been set at a level to allow for a proportion of breaches due to patient choice and medical issues.

Adjustments are allowed in two places:

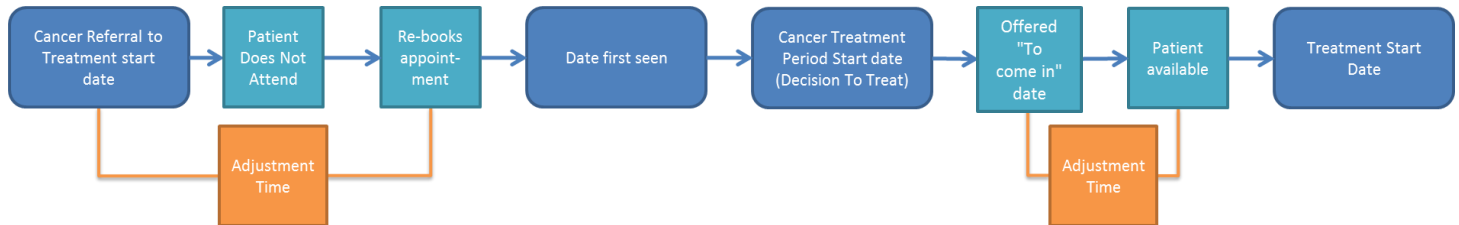
- if a patient DNAs (ie does not turn up and gives no notice) their initial out-patient appointment/diagnostic clinic that would have been recorded as [DATE FIRST SEEN](#) then the clock can be re-set from the receipt of the referral (recorded as the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#)) to the date upon which the patient makes contact to rebook their appointment (not the date of the new appointment). This period is called the [WAITING TIME ADJUSTMENT \(FIRST SEEN\)](#) and is effectively deleted from the waiting time
- if a patient declines a '[reasonable](#)' offer of admission for treatment in an admitted care (ordinary admission or day case) setting. For cancer patients under the 31 or 62 day standard the adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.

For cases where the patient is unavailable for a period of time, such as a holiday, then this adjustment can be continued until the patient makes themselves available again. Any delay after that for medical suspensions or capacity issues would not be included in the adjustment.

The operational standard allows for a patient who is not clinically able to be seen within the standard timescales eg. a prostate patient that needs to wait between a TRUS biopsy and an MRI.

These adjustments came into effect on the 1st January 2009 and are not applicable to cases before this date.

Figure 3 ADJUSTMENT FOR DNA and To Come In date



7.1.1 If a patient DNAs their initial out-patient appointment (OPA), how should the process of re-booking be managed?

If a patient [DNAs](#) their initial OPA it is suggested that if the local provider does not hear from the patient they should seek to proactively contact the patient (eg by phone) to start the process of re-booking.

However, if a patient cancels their first out-patient appointment and then DNAs the rearranged date the DNA 'trumps' the cancellation and the clock can be reset to the date the patient re-books the appointment.

7.1.2 Can adjustments be used when a patient cancels an appointment?

A cancellation of a To Come In date does not count as a refusal for admitted treatment and no pause can be used here.

7.1.3 What is the difference between a Cancellation and a DNA?

A DNA is where a patient does not turn up, turns up late or turns up in a condition where it is not possible to carry out whatever was planned for them eg if they have not taken a preparation they needed to take prior to the appointment.

If the patient arrives after the scheduled appointment time and it is not possible to fit them in (eg fully booked) or there is not enough time left to carry out the planned procedure/tests in the remainder of the session then this could be classed as a DNA.

A cancellation is when a patient gives any advance notice. A cancellation is a cancellation even if notice is very short.

By cancelling an appointment a patient has shown a willingness to engage with the NHS.

If it is not possible to see a patient who arrived on time for their appointment due to the clinic running late, staff shortages etc and the patient has to leave before they have been seen, this is a cancellation.

7.1.4 Can an adjustment be made if a patient DNAs the first out-patient appointment after a consultant upgrade onto a 62 day standard?

The adjustment for when patients [DNA](#) the first out-patient appointment can be used for the consultant upgrade route up to the [DATE FIRST SEEN](#). As most referrals along this route occur at the same time as the date first seen. This adjustment will be rare but could occur if a consultant upgrades a patient after reading a referral letter but then the patient DNAs.

7.1.5 Can adjustments be made if a patient DNAs a diagnostic appointment?

An adjustment is only possible if a patient DNAs their first out-patient appointment. DNAs elsewhere in the pathway have been taken into account in the operational standards.

7.1.6 Can multiple DNAs count as refusal of tests?

A DNA is not the same as a refusal to have a test. A refusal is when a patient has informed the NHS that they do not want to proceed with a test(s) or treatment(s) and can therefore be removed from the applicable cancer waits pathway. The NHS cannot assume that by DNAing an appointment the patient is refusing to have the test(s) at all.

7.1.7 If a patient DNAs or cancels an agreed TCI date can an adjustment be made?

If a patient has agreed to a reasonable offer which they subsequently cancel/DNA, no pause is allowed and the clock continues.

As part of the re-booking process the patient should be offered alternative dates for admission. If at the re-booking stage the patient declines a reasonable offer of admitted treatment then an adjustment can be made. The clock is paused from the date of the earliest reasonable offer given. The end of the pause will be the new date that the patient states they are available from.

7.1.8 If a patient states at an appointment that they are unavailable for a set period of time (eg on holiday) before a [reasonable](#) date has been offered, is it legitimate to pause the clock if an appointment could have been offered during those times?

Where a patient makes themselves unavailable for an appointment for a set period of time then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the provider would be offering dates that they know the patient cannot attend). In these circumstances the clock can be paused from the date of the earliest reasonable offer that the provider would have been able to offer that patient. The clock would restart when the patient makes themselves available again. This does not apply to [religious events](#).

- 7.1.9 A patient is offered an appointment for admitted treatment which they decline as they have a holiday booked. They can't be offered a surgical appointment as soon as they return as they will have a high risk of deep vein thrombosis following a transatlantic flight. When would they be considered as making themselves available again and the clock restarting?**

The clock restarts when the patient makes themselves available again ie when they are back from their holiday. Any wait after that due to risk of DVT would have been a medical suspension under the old methodology so no adjustment is possible for this part of the pathway.

- 7.1.10 What is the position on adjustments if a patient wishes to wait for a specific treatment option?**

If the patient has been offered a choice of treatments and they opt for one where there is insufficient capacity to provide the treatment within the standard deadline then it would not be possible to use an adjustment.

If you offer a choice of treatments and the patient asks about another treatment that, for example, the patient has heard about and, on reflection, it is deemed an appropriate treatment option then an adjustment would be possible as the patient declined a reasonable offer of treatment initially. The adjustment would be from the [TCI](#) date that would have been offered and the clock restarts when the patient makes themselves available for a further appointment.

If an earlier appointment for the required treatment becomes available then it is good practice to offer this to the patient. If the patient already has a [reasonable](#) offer that they have agreed to and so decline this earlier offer then no adjustment should be applied.

- 7.1.11 What is the position on adjustments if a patient wishes to wait for an admitted treatment under a specific consultant or provider?**

If a patient is given a reasonable offer of treatment with provider/consultant/location X but requests provider/consultant/location Y who can't offer them an appointment within the standard time then an adjustment can be made as long as treatment with provider/consultant/location Y was not offered originally as an option.

- 7.1.12 If the patient is unavailable due to a religious event can an adjustment be made?**

No, the pathway should not be adjusted for matters of patient choice due to religious events. The time delay caused by patients attending religious events is taken into account in the set operational standards.

- 7.1.13 If a patient has been admitted for surgery but then changes their mind and does not proceed with the treatment can an adjustment apply?**

If the patient decided that they did not want any treatment then you would end the period on the date that this was agreed and record the [CANCER TREATMENT MODALITY](#) as code 98 'All treatment declined'.

If they agree to a different form of treatment then you would use the [DTT](#) date for the newly agreed treatment as the starting point for the relevant 31 day period. You cannot make any adjustments for the 62 day period for a patient considering treatment X then declining and agreeing to treatment Y instead. With surgery, the clock would normally stop when the patient has been admitted (ie prior to the surgery itself if it was planned for the next day etc), however the admission date would not have stopped the 62 day clock in this example as the episode of care did not end with the treatment.

7.1.14 **Are regular day attenders classed as admitted or non-admitted care?**

There are two different types of regular day admission for cancer services, each of which may have a different admission status that should be considered when submitting data to form patient records for cancer waiting times. The different types of regular attender are:

- **Regular Day Admission** - where a patient is admitted electively during the day as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions involves a stay of at least 24 hours, such an admission should be classified as an ordinary admission. This series of regular admissions ends when the patient no longer requires frequent admissions
- **Regular Night Admission** - where a patient is admitted electively for the night as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions involves a stay of at least 24 hours, such an admission should be classified as an ordinary admission. This series of regular admissions ends when the patient no longer requires frequent admissions.

Both of these types of regular attendance include an admission, therefore they should be considered to be care in an admitted setting.

If the patient is being invited back for multiple outpatient attendances but no admission is made then that episode of care should not be considered a Regular Day Admission and the episode of care should not be recorded as being within an admitted environment within the CWT-Db as it is merely an outpatient activity.

7.2 **Patient Choice**

No pauses are applied to thinking time the patient may take or to the time period waited because the patient might have to wait longer to receive one treatment modality among the options given than another or because the patient might have to wait longer to receive treatment offered by different providers.

Active monitoring is not an acceptable substitute for thinking time.

7.2.1 How should we manage patients who decline an initial treatment but later choose to have treatment?

Providing the patient is fully aware of what they have asked for and they know this is not just time to think then they are making an informed choice to decline all treatment and this would be recorded as Code 98 (all treatment declined) in the [CANCER TREATMENT MODALITY](#) field.

If the patient later agreed to treatment this would be a separate 31 day subsequent treatment period.

7.2.2 How do we monitor a patient who agrees a treatment and later changes their mind and wishes to receive a different treatment altogether?

The patient will have to agree a new [DTI](#) for the new treatment option and the 31 day clock is reset. The 62 day clock (if appropriate) would continue.

8 Breaches

A breach is shared between the provider commissioned to carry out the appointment classed as [DATE FIRST SEEN](#) and the provider commissioned to carry out the treatment ([TREATMENT START DATE \(CANCER\)](#)). The provider treating the patient should always fully explain on the CWT-Db the reason for the breach. The sharing of the breach is done automatically by Open Exeter.

A 31-day pathway is not a shared activity.

In a small number of cases there will be good clinical reasons for treatment times exceeding the operational standards. For example:

- a patient where there is diagnostic uncertainty as to whether they have cancer or not who may require repeat diagnostic tests in order to reach a diagnosis
- a patient who requires a particularly complex combination of scans and biopsies; and
- a patient for whom there is genuine clinical uncertainty about the diagnosis.

Adjustments have never been allowed for these patients. The operational standard has always (and still does) take into account these clinical exceptions.

In addition, there will be a proportion of patients that choose to wait longer than the standard time or are unfit, for whatever reason, to proceed with appointments/treatment within these timescales. The operational standards have taken these patients into account.

Reports on breaches are required on all patients that wait longer than the relevant operational standard time (including when there are good clinical reasons or patient choice was a factor). The report should be a summary including how long the patient waited, the reason for the breach and the action put in place to prevent further similar avoidable breaches. Breach reports submitted via the [CWT-Db](#) should not contain the name of the patient, the clinician(s) responsible for their care or other personal details.

8.1.1 **Will CWT consider introducing a breach reallocation process or a cut-off point for referrals after which the treating provider will not be expected to meet the 62-day standard?**

NHS England is currently looking into the breach reallocation policy and how this can be amended within the current system to be fairer to individual providers.

Until a change is finalised, treating providers are encouraged to work with their local networks to develop the diagnostic and transferral process. The [REFERRAL REQUEST RECEIVED DATE \(INTER-PROVIDER TRANSFER\)](#)

field was specifically created to help clarify the transfer to a treating provider and should be used for local analysis by commissioners and networks.

8.1.2 If a patient is having a combined treatment the clock stops when the first part of the treatment starts. If the two parts are given by different providers eg chemotherapy first in Provider A then radiotherapy in Provider B what happens with any breaches?

A 62 day breach is shared by the provider commissioned to first see the patient and the provider commissioned to carry out the treatment. In terms of a combination treatment if two providers split the treatments (ie one does the chemotherapy and one the radiotherapy), it would be the provider commissioned to deliver the first part of the combination treatment, in this example the chemotherapy, that would share any resulting 62 day breach and would have the whole of any 31 day breach.

9 Tumour Specific

We recognise that the care pathways for patients with different tumour types can be very different and the operational standards are for performance as a whole ie all tumours taken together. It is not expected that all tumour groups will meet that level of performance – this is not realistic and would not be in the best interest of all patients.

9.1 Cancers of the Brain and Central Nervous System (CNS)

In Scope:

- [WHO](#) Grade 3 & 4 tumours (generally considered malignant)
- [ICD](#)10 codes C47, C69-72.

Out of Scope:

- WHO Grade 1 & 2 tumours (generally considered benign)
- Von Hippel-Landau syndrome – a benign condition.

9.1.1 **A tumour was WHO grade 2 on de-bulking and radiotherapy was given. The patient then had a WHO Grade 3 tumour in the same area. Is this classed as recurrence or a new primary?**

For cancer waits the Grade 3 tumour should be reported as a new primary as the Grade 2 tumour was outside the scope of cancer waits.

9.1.2 **What cannot be classified as a [FDI](#) for Brain & CNS cancers?**

- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)
- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Dexamethasone (unless described as palliative care with no other anti-cancer treatment being planned).

9.1.3 **What cannot be classed as subsequent treatment for Brain & CNS cancers?**

- any cosmetic procedures
- rehabilitation such as speech & language therapy and psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.1.4 **Are kyphoplasty and vertebroplasty reported as subsequent cancer treatments?**

These treatments would only apply for patients where any vertebral compression fractures were caused by malignant disease.

9.2 Breast Cancer

In Scope:

- [ICD](#)10 code C50
- ICD10 code D05 (ie breast cancer in situ. Both ductal carcinoma in situ [DCIS] and lobular carcinoma in situ [LCIS] are covered by D05)
- Paget's disease of nipple/breast - clinical coders and cancer registries code this condition as ICD10 Code C50.

Out of Scope:

- Atypical Ductal Hypoplasia.

9.2.1 What cannot be classed as first treatment for breast cancers?

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Sentinel Lymph Node Biopsy – this is a diagnostic staging procedure to determine whether the cancer has spread to the lymph nodes
- Tamoxifen – hormone treatment can only be classed as [FDT](#) if it is to be the sole treatment modality or the treatment plan specifies that a second treatment modality should only be given after a planned interval. For example, unless the [MDT](#) has recommended that neoadjuvant therapy is necessary Tamoxifen prior to surgery would not be first treatment. In this case surgery should be reported as the first treatment rather than the start of Tamoxifen even if it is necessary to wait to assess a response to Tamoxifen
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.2.2 What cannot be classed as a subsequent treatment for breast cancer?

- reconstructive surgery (ie carried out at a different time to the mastectomy)
- cosmetic procedures eg bilateral revision of mastectomy scars
- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.2.3 A patient is treated for breast cancer in the right breast but decides to have a left mastectomy albeit there are no current issues with her left breast. Would removal of her left breast be exempt from cancer waits?

If this is a purely prophylactic treatment then this would not be a subsequent treatment for cancer waits.

9.3 Children's Cancer

For the purposes of cancer waits a child is under 16 years of age at receipt of an urgent referral for suspected cancer (if relevant) or under 16 at decision to treat.

To record a record for a child where cancer is suspected use '02' in the field [TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE](#).

Children are covered by the following cancer waits standards:

- two week wait referral for suspected cancer and breast symptoms (where cancer not suspected)
- 31 day from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to treatment (ie equivalent of the 62 day urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to treatment for adults)
- 31 day first and subsequent treatments
- 62 day upgrade.

Children are not differentiated in the two week wait for breast symptoms (where cancer is not suspected). Code '16' is used as normal.

9.3.1 What is the operational standard for the 31 day referral to treatment for children's cancers?

There has never been an individual operational standard for this 31 day measure as the patient numbers involved are too small to reliably calculate one or use it for performance management on a monthly/quarterly basis. These referral to treatment periods are a subset of the 62 day referral to treatment standard, therefore NHS England will add them to the numerator and denominator for that standard and apply the 85% operational standard.

9.3.2 How is the 31day referral to treatment pathway for children monitored?

There is a separate report "Report 3.7 – the Cancer Plan 31-Day Rare Cancer Standard Report" downloadable from Open Exeter.

Additionally, the patients covered by this 31 day standard are included within the numerator and denominator of the 62-day all cancer National Statistics published by the NHS England and all performance analyses and reports it shares with the NHS on a periodic basis.

These patients are reported separately within the [CWT-Db](#) to enable your organisation to correctly manage services to ensure that all patients within the acute leukaemia, testicular cancer and children's cancers cohorts, who are fit, able and willing to be treated, receive treatment within 31 days of the receipt of the initial urgent referral into secondary care.

9.3.3 Are children's cancers (which currently run on a 31 day period from urgent referral to treatment) included in the upgrade standard and, if so, would that put them on a 31 day or 62 day period from the point of upgrade?

A consultant (or an authorised member of the consultant team) would be able to upgrade patients they suspected might have one of these cancers but who had not been urgently referred on to a 62 day period. The upgrade would be on to the 62 day period but it would be deemed as good practice for the locality to seek to deliver the treatment within 31 days where possible. The same would apply to any routine referral where the patient went on to be diagnosed with testicular cancer or acute leukaemia.

9.4 Gynaecological Cancers

In Scope:

- [ICD](#)10 codes C51-58

Out of Scope:

- colposcopy referrals from cervical screening programme (other than those for moderate or severe dyskaryosis, invasive or glandular neoplasia).

9.4.1 What cannot be classed as first treatments for gynae cancers?

- cone or loop or LLETZ biopsy/hysteroscopy/colposcopy/vulvoscopy if diagnostic in intent only – however, if therapeutic in intent (ie if the intention of the procedure was to remove the tumour) then these would count as first treatment irrespective of whether the margins were clear. If the intention was diagnostic but the tissue was found to be malignant the procedure could count as first treatment if the tumour had effectively been removed by the excision
- removal of polyps for diagnostic purposes – however, if the tissue was found to be malignant the procedure could count as first treatment if the tumour had effectively been removed by the excision
- removal of para-aortic nodes before a patient starts radiotherapy or chemotherapy - this is not classed as a therapeutic procedure unless clinically involved nodes are having to be de-bulked prior to radiotherapy
- ileal conduit urinary diversion surgery to treat a bladder problems prior to active treatment eg chemoradiation
- removal/draining of ascites prior to chemotherapy (unless no other active treatment is planned)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.4.2 What cannot be classed as a subsequent treatment for gynae cancers?

- reconstruction post-surgery
- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.4.3 Is the removal of pelvic lymph nodes considered a first treatment for cervical cancer?

The removal of pelvic lymph nodes as part of a two part operation to treat cervical cancer can be classed as first treatment. The second stage treatment (determined by the status of the nodes) would be covered by the 31 day subsequent treatment standard.

9.4.4 Can pleural effusion/pleurodesis be a subsequent treatment for a gynae patient?

Pleural aspiration or drainage (for pleural effusion) or pleurodesis (surgical or medical) could be counted as a subsequent treatment.

However, if it is part of a palliative support package the start of the package of care would be taken as the:

- date of the delivery of the first episode
- the consultation that results in the referral to a non-NHS specialist palliative care service
- the consultation at which the patient receives a prescription.

So unless any of these procedures was the first episode in the package they are unlikely to be counted.

9.4.5 A gynae patient was treated and the full tumour was removed at that time. The patient was then given the choice of completion surgery (ie a hysterectomy) - is this classed as a subsequent treatment?

Yes. This would be classed as a 31 day subsequent treatment as it is part of the cancer care package.

9.4.6 Are any adjustments possible if a patient's diagnostic tests/treatments have to be delayed due to the menstrual cycle, pregnancy or a recent termination of pregnancy?

No, adjustments are not possible. A medical suspension would have been allowed under the old rules. Under the new rules the operational standard takes into account the fact that some patients will not be clinically fit to be treated within 62 days of a two week wait urgent suspected cancer referral or a PRIORITY TYPE '2' (urgent) referral from the cervical screening programme.

9.5 Haematological Cancers

In Scope:

- [ICD](#)10 codes C81-C97 including:
 - chronic lymphocytic leukaemia
 - chronic myelomonocytic leukaemia (CMML) - for the purposes of cancer this is classed as a form of leukaemia rather than a form of myelodysplastic syndrome although it is noted that many are not clinically urgent
 - B-cell chronic lymphocytic leukaemia (CLL)
 - Small Lymphocytic Lymphoma (SLL)
 - all cases of acute leukaemia.

Out of Scope:

- Myeloid dysplastic syndrome (D46.A or D46.B).

9.5.1 What cannot be classed as first treatment for haematological cancers?

- removal of Lymph Nodes – this will be a biopsy to establish a diagnosis of Lymphoma and there is likely to be additional disease throughout the body that will need active treatment
- blood transfusions – unless a patient has no other active treatment planned, in this case the transfusions would be classed as palliative treatment
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.5.2 What cannot be classed as a subsequent treatment for haematological cancers?

Rehabilitation, such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.5.3 Are antibiotics a valid first treatment for low grade gastric lymphomas?

Antibiotics would count as the start of treatment for low grade gastric lymphoma.

9.5.4 Can total body radiation/cycles of chemotherapy prior to a bone marrow transplant (BMT) be classed as a first treatment?

For a patient who is having a bone marrow transplant and is admitted prior to the transplant for conditioning eg total body radiotherapy then the admission date would stop the clock on the condition that the BMT itself took place within the same episode of care.

For patients receiving chemotherapy it is advised that this is classed as a treatment package where the pathway ends with the start of the chemotherapy.

9.5.5 **Are blood transfusions counted as subsequent treatments?**

Palliative treatments can count as subsequent treatments so a blood transfusion could be covered by the 31 day subsequent treatment standard. However an agreed package of palliative care would only count as one treatment with the first treatment in the agreed palliative care package marking the end of the 31 day period.

9.5.6 **If a patient is diagnosed with one haematological condition that transforms to a different type, how is this managed in cancer waits?**

The relevant cancer waits data item is [CANCER TREATMENT EVENT TYPE](#). This includes:

- code 09 (Treatment for relapse of primary cancer (second or subsequent)); and
- code 10 (Treatment for progression of primary cancer (second or subsequent)).

As haematological cancers do not spread/recur in the same way as solid tumours, haematologists consulted during the development of the updated cancer waits standards advised including these descriptions within the coding structure. It is for clinical teams locally to decide which is the most appropriate category to use for their haematological patients.

9.6 **Head & Neck Cancers (incl. thyroid cancer)**

In Scope:

- [ICD](#)10 Codes: C00 – C14, C30 – C32, C73, C77.0

Out of Scope:

- Barrett's oesophagus

9.6.1 **What cannot be classed as first treatment for head, neck or thyroid cancers?**

Head & neck

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- dental clearance eg prior to radiotherapy
- insertion of a percutaneous endoscopic gastrostomy (PEG) for nutrition to make patients fit for active treatment prior to radiotherapy
- insertion of a PEG prior to surgery (unless the PEG is carried out within the same episode of care as the surgery – ie if the patient is admitted for the PEG and is not discharged prior to the main surgery then the admission date for the PEG ends the cancer waits pathway)

- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Thyroid

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.6.2 **What cannot be classed as a subsequent treatment for head, neck or thyroid cancers?**

Head & neck

- reconstructive surgery post treatment
- rehabilitation such as speech & language therapy and psychosocial support eg cognitive behavioural therapy, physiotherapy etc
- management of side effects
- closure of tracheostomy
- dealing with leaking/blocked voice prostheses, breathing/swallowing problems
- surgical voice restoration.

Thyroid

- rehabilitation such as speech & language therapy and psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.6.3 **If a stent is changed every 6 weeks due to being outgrown or blocked or laser treatment is used to unblock a stent – is each procedure classed as a subsequent treatment?**

Each stent change or clearing does not need to be a subsequent treatment if it is not active treatment of the cancer.

9.7 **Lower-Gastrointestinal Cancers – LGI (colon, rectal, anal)**

In Scope:

- [ICD10](#) Codes: C17 – C21, C26

Out of Scope:

- carcinoma in situ (CIS) found in polyps excised at colonoscopy - CIS includes cancer cells confined within the glandular basement membrane (intraepithelial) or lamina propria (intramucosal) with no extension through muscularis mucosae into submucosa
- carcinoids of the appendix (coded as ICD10 D37.3).

9.7.1 What cannot be classed as first treatment for LGI cancers?

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.7.2 What cannot be classed as subsequent treatment for LGI cancer?

- closure of a temporary stoma
- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.8 Lung Cancers

In Scope:

- [ICD10](#) Codes: C33 – C39, C45 (C78 for secondary after unknown primary)

9.8.1 What cannot be classed as first treatments?

Lung cancer

- drainage of a pleural effusion if further anti-cancer treatment is planned
- pleurodesis if further anti-cancer treatment is planned
- mediastinoscopy - unless the excised tissue was found to be malignant and the tumour had effectively been removed by the excision irrespective of whether the margins were clear – this is unlikely
- stenting of the airway or superior vena cava if further anti-cancer treatment is planned
- laser treatment of major airways obstruction if further anti-cancer treatment is planned
- VATS biopsy (Video Assisted Thoracic Surgery) for diagnostic purposes unless procedure could be considered as de-bulking the tumour
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)
- surgery or radiotherapy for brain metastases - treatment of metastases cannot be classed as first treatment unless it is for metastases of primary of unknown origin.

Mesothelioma

- drainage of a pleural effusion if further anti-cancer treatment is planned
- pleurodesis if further anti-cancer treatment is planned

- interventional analgesia (eg nerve block or cordotomy) if further anti-cancer treatment is planned
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.8.2 **What cannot be classed as subsequent treatments?**

Lung cancer

- antitussives such as codeine, morphine, dihydrocodeine or hydrocodone (for coughs)
- opioids (for breathlessness and pain management)
- corticosteroids for problems other than cerebral metastases
- bisphosphonates for bone pain
- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

Mesothelioma

- non-invasive analgesia (e.g. opioids)
- corticosteroids for problems other than cerebral metastases
- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.8.3 **Does talc pleurodesis count as a subsequent treatment for lung cancer?**

It can be classed as a subsequent treatment. However, if talc pleurodesis was one part of an agreed supportive care package then it is only the start of the package that counts. If it is in addition to an agreed package it could count in its own right.

9.8.4 **How are pleural effusions recorded by cancer waits standards?**

Managing pleural effusions could only be classed as first treatment if no further anti-cancer treatment is planned.

There is no perfect answer for coding pleural effusions. It is best to code them as either non-specialist palliative care (Code 09) or specialist palliative care (Code 07) as per advice of your local clinical team. Some pleurodesis procedures are carried out by surgeons under general anaesthetic (probably no more than 5% of the total) so some could legitimately be coded as surgical procedures.

9.8.5 **How should management of ascites be covered by cancer waits standards?**

Managing ascites would only be classed as first treatment if no further anti-cancer treatment is planned.

9.9 Sarcoma

In Scope:

- [ICD10](#) C40-41,46, 48-49 &,79.5 (secondary with unknown primary)
- Kaposi's sarcoma (malignant tumour arising from blood vessels in the skin) - rare in the western world except for patients with Aids
- Fibrosarcoma.

Out of Scope

- Fibromatosis

9.9.1 What cannot be classed as first treatment for sarcomas?

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.9.2 What cannot be classed as a subsequent treatment for sarcomas?

- reconstructive surgery post definitive treatment
- rehabilitation, such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.10 Skin Cancers

In scope:

- [ICD10](#) Codes: C43 – C44

including:

- Malignant Melanomas
- Merkel Cell Carcinoma
- Squamous Cell Carcinoma (SCC)
- excluding the following conditions classified under C44:
 - Basal Cell Carcinoma
 - Multicentric Basal Cell Carcinoma
 - Basal Cell Carcinoma, Morphoea
 - Basal Cell Carcinoma, Fibroepithelial
 - Basosquamous Carcinoma
 - Metatypical Carcinoma
 - Pilomatrix Carcinoma
- Kaposi's Sarcoma
- Cutaneous lymphomas.

Out of Scope:

- Lentigo Malignas (considered Carcinoma In Situ)
- Bowen's Disease (considered Carcinoma In Situ)
- Intraepidermal Carcinomas (considered Carcinoma In Situ)
- Keratoacanthoma - benign condition not malignant.

9.10.1 Do we only track the first skin squamous cell carcinoma (SCC) a patient has?

Each SCC is covered by the cancer waits standards not just the first.

Whether or not a SCC or Malignant Melanoma (MM) is classed as a new primary or a recurrence is a local clinical decision.

If a patient has multiple SCCs (or MMs) with the same ICD-10 coding and they can all be treated as part of the same appointment with the same treatment, pragmatically these could be classed as one 31 day pathway.

9.10.2 What cannot be classed as first treatment for skin cancers?

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- Sentinel Node Biopsy – this is a diagnostic staging procedure to determine whether the cancer has spread to the lymph nodes
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.10.3 What cannot be classed as a subsequent treatment for skin cancers?

- reconstructive/cosmetic surgery post initial (definitive) treatment
- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.10.4 A patient has a skin lesion excised at the GP surgery which is confirmed on histology as a malignant melanoma. The GP then makes a two week wait referral. The patient is seen within 2 weeks and listed for a wider excision. Histology shows no residual malignancy. How should this be recorded for cancer waits?

A two week wait referral should be made when a GP suspects cancer. In this scenario a cancer has been diagnosed/treated prior to the referral.

It is advised that:

- if the margins were clear after the GP treatment (and he considers that to be the first treatment) then record the two week wait period and a 31 day [FDT](#) period for the GP treatment - FDT is sequentially before the two week period and therefore will not be linked as a 62 day period. Any other treatment that follows would be classed as a subsequent 31 day period

- if margins are not clear after the GP procedure (assuming it was diagnostic in intent) then you would class the 31 day period in the secondary care as the first treatment which would then link to the two week wait referral period and create a 62 day period.

9.11 Upper Gastrointestinal Cancer (oesophageal, stomach, pancreatic, liver)

In Scope:

- [ICD10](#) Codes: C16 – C17, C22 – C25
- gastrointestinal stromal tumours (GISTs) that are described as malignant, invasive or as having metastases coded to the relevant ICD10 'C' code for the part of the gastro intestinal tract involved.

Out of Scope:

- GISTs not specified as above, coded as borderline using the relevant 'D' code.

9.11.1 How should rare neuroendocrine tumours be coded – the diagnosis is not always specific to pancreatic origin?

The cancer waits database does not use morphology coding. It is therefore suggested that you code the primary site of origin of the tumour (ie record the ICD10 site as the primary site of origin) and not the fact that it is of a neuroendocrine type. Although the tumours are called neuroendocrine they do not necessarily arise in an endocrine site. If the primary site is genuinely not known then use a "Malignant neoplasm of other and ill-defined sites" code. This would be C76 but as the fourth digit is now required you should add more detail.

9.11.2 What cannot be classed as first treatment for upper GI cancers?

Pancreatic cancer

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- insertion of pancreatic/biliary stent - if the planned first treatment is resection for pancreatic or related cancers (ampullary, duodenal and distal bile duct) and the patient requires a stent due to having had to wait for the surgery
- insertion of pancreatic/biliary stent - for patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) if local practice is that they do not require biliary stenting before resection if surgery and imaging are planned within 7-10 days
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

Gastric/oesophago-gastric cancer

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- jejunostomy to insert a feeding tube
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.11.3 What cannot be classed as a subsequent treatment for UGI cancers?

- rehabilitation such as psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.11.4 When can a pancreatic stent be classed as first treatment?

It could be classed as a first treatment if planned to resolve jaundice before a patient has a resection or starts chemotherapy. However, many clinicians agree that patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) do not require biliary stenting before resection if surgery and imaging are planned within 7-10 days. If this is the agreed clinical practice locally then stenting these patients will not count as first treatment.

9.11.5 Is a staging laparoscopy to determine whether a patient is suitable for major UGI surgery classed as first treatment?

The date of admission for the staging laparoscopy could be counted at the start date for first treatment if that treatment was surgery and the patient remained an in-patient between the admission for the laparoscopy and the surgery ie if it is the same episode of care.

9.12 Urological Cancers (bladder, prostate, renal, testicular, upper tract transitional cell)

In Scope:

- [ICD](#)10 Codes: C66-C67 [Bladder]
- ICD10 Code: C61 [Prostate]
- ICD10 Codes: C64-C65 [Renal/Kidney]
- ICD10 Code: C60 [Penile]
- ICD10 Code: C62 [Testicular]
- ICD10 Codes: C65-66 [Upper tract transitional cell carcinoma (renal pelvis or ureter)].

Out of Scope:

- pTa – transitional cell carcinoma is regarded as non-invasive [Bladder]

9.12.1 What cannot be classed as first treatment for urological cancers?

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment).

9.12.2 What cannot be classed as a subsequent treatment for urological cancers?

- reconstructive surgery
- rehabilitation such as speech & language therapy and psychosocial support eg cognitive behavioural therapy, physiotherapy etc.

9.12.3 A patient has had bladder surgery and then returns some time later for Mitomycin. Is this a subsequent treatment?

Mitomycin is adjuvant chemotherapy in this scenario and would thus be classed as a subsequent treatment. Although, if the Mitomycin is given only a short time after the surgery (eg 24 hours) then this could be classed as a combined treatment and thus would not be a subsequent treatment.

10 Cancer Waiting Times Database (CWT-Db) – Support and Information

10.1.1 What other guidance documents are available?

All the available guidance is stored at

<http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>.

This includes:

- National Cancer Waiting Times User Manual
- National Cancer Waiting Times Reports User Manual
- NHS Communications outlining the establishment of and changes to the National cancer waiting times data set
- this guidance and previous versions of this guidance
- the table of clinical codes acceptable to the CWT-Db.

10.1.2 What support is available/how can I send questions?

Queries about the cancer waiting times rules or publications can be sent to cancer-waits@dh.gsi.gov.uk.

You can also contact the Open Exeter helpdesk on 0300 303 4034 for queries about the data submission process or the automatically generated Open Exeter reports.

10.1.3 How is the data collected?

The cancer waiting times data is collected on a monthly basis.

At 17:00, 25 working days after the end of each month, a snap shot is taken of all the uploaded records for that month. However, the database remains live and records can still be changed up until the end of a quarter (note that for the last month in a quarter the monthly cut-off and quarterly cut-off are the same).

At 17:00, 25 working days after the end of the last month in each quarter, an additional snapshot is taken of all the records within that quarter. Once this snapshot is taken no further records can be uploaded or amended for that quarter.

A full list of report generation dates can be found in the Health and Social Care Information Centre Support section of http://systems.hscic.gov.uk/ssd/cancerwaiting/prop_reports.

10.1.4 What do we do if an error is found after the monthly deadline has passed?

Once a monthly report has been published by NHS England revisions are not applied. However, as the quarterly reports are not produced as an aggregate of the three monthly reports, it is possible to correct an error in a monthly upload prior to the quarterly reports being produced. The quarterly reports will then show the corrected data whilst the monthly reports will show the originally uploaded data.

10.1.5 What do we do if an error is found after the quarterly deadline has passed?

When an error has occurred or records have been missed then you should contact cancer-waits@dh.gsi.gov.uk. If the error impacts the overall performance then a footnote can be applied to the published workbooks.

10.1.6 How do we upload data to the CWT-Db?

The data is uploaded to Open Exeter. Documents describing the process of uploading and downloading data can be found in the Health and Social Care Information Centre Support section of <http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>.

The database allows records to be automatically updated as a group. It is envisaged that the majority of records will be uploaded in bulk once per month. Manual uploads are also possible although not recommended for a large number of records or as a long term solution. An individual record can be manipulated manually (provided the correct NHS Number is submitted) after it has been uploaded up until the cut-off date at the end of the quarter.

10.1.7 Where can I see the quarterly publications produced from the CWT-Db data?

Publications before Q2 2011/12 have been archived but can be viewed by following the links on the [NHS statistics page for cancer waiting times](#).

10.1.8 How can we suggest changes to the CWT-Db?

If you have suggestions for how the CWT-Db could be enhanced and improved these should be logged with the Open Exeter helpdesk on 0300 303 4034 or with the Cancer Waiting Times team at cancer-waits@dh.gsi.gov.uk.

11 Annex: National Cancer Dataset: Waiting Times Subset (NCWTMDS)

The National Cancer Waiting Times Monitoring Dataset (NCWTMDS) contains 40 data items required for monitoring the cancer waiting time standards set out in the document 'Improving Outcomes: A Strategy for Cancer'.

The 40 data items are categorised in the table below including information on what data items are required in a range of different health care scenarios defined as follows:

Scenario 1:

The Health Care Provider where the patient is first seen following a referral request with priority type 'Two Week Wait', or where an urgent referral is from a NHS cancer screening programme.

Scenario 2:

The Health Care Provider where the patient receives First Definitive Treatment for cancer following a referral request with priority type 'Two Week Wait', or where an urgent referral is from a NHS cancer screening programme.

Scenario 3:

The Health Care Provider where the patient receives second or subsequent treatment for cancer following a referral request with priority type 'Two Week Wait', or where an urgent referral is from a NHS cancer screening programme.

Scenario 4:

The Health Care Provider where the patient receives First Definitive Treatment for cancer following a consultant upgrade onto a 62 day patient pathway.

Scenario 5:

The Health Care Provider where the patient receives second or subsequent treatment for cancer following a consultant upgrade onto a 62 day patient pathway.

Scenario 6:

The Health Care Provider where the patient receives First Definitive Treatment for cancer following a referral request from another [SOURCE OF REFERRAL FOR OUT-PATIENTS](#) or a different priority type.

Scenario 7:

The Health Care Provider where the patient receives second or subsequent treatment for cancer following a referral request from another [SOURCE OF REFERRAL FOR OUT-PATIENTS](#) or a different priority type.

Key:

M	= Mandatory
M*	= Mandatory if applicable
O	= Optional
O*	= Optional if applicable
N/A	= Not Applicable

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
Patient Information							
NHS Number	M	M	M	M	M	M	M
NHS Number Status Identifier Code	M	M	M	M	M	M	M
Patient Pathway Identifier	M	M*	M*	M*	M*	M*	M*
Provider Information							
Organisation Code (Patient Pathway Identifier Issuer)	M	M*	M*	M*	M*	M*	M*
Site Code (Of Provider Consultant Upgrade)	n/a	n/a	n/a	M	n/a	O	n/a
Site Code (Of Provider First Seen)	M	n/a	n/a	M	n/a	n/a	n/a
Site Code (Of Provider Decision To Treat (Cancer))	M*	M	M	M	M	M	M
Site Code (Of Provider Treatment Start Date (Cancer))	n/a	M	M	M	M	M	M
Dates							
Cancer Referral to Treatment Period Start Date	M	M	n/a	O	n/a	O	n/a
Consultant Upgrade Date	n/a	n/a	n/a	M	n/a	O	n/a
Date First Seen	M	n/a	n/a	M	n/a	O	n/a
Cancer Treatment Period Start Date	n/a	M	M	M	M	M	M
Treatment Start Date (Cancer)	n/a	M	M	M	M	M	M
Referral Request Received Date (Inter Provider Transfer)	n/a	M*	M*	M*	M*	M*	M*
Cancer Information							
Two Week Wait Cancer Or Symptomatic Breast Referral Type	M	n/a	n/a	n/a	n/a	O	n/a
Primary Diagnosis (ICD)	n/a	M	M	M	M	M	M
Tumour Laterality	n/a	M	M	M	M	M	M
Metastatic Site	n/a	M*	M*	M*	M*	M*	M*
Treatment Information							
Cancer Treatment Modality	n/a	M	M	M	M	M	M
Cancer Care Setting (Treatment)	n/a	M	M	M	M	M	M
Clinical Trial Indicator	n/a	M	M	M	M	M	M
Radiotherapy Priority	n/a	M*	M*	M*	M*	M*	M*
Radiotherapy Intent	n/a	M*	M*	M*	M*	M*	M*
Source of Referral for Outpatients	M	n/a	n/a	M	n/a	O	n/a
Priority Type Code	M	n/a	n/a	M	n/a	O	n/a
Cancer or Symptomatic Breast Referral Patient Status	M	M	M	M	M	M	M
Cancer Treatment Event Type	n/a	M	M	M	M	M	M
Decision to Refer Date (Cancer or Breast Symptoms)	M*	n/a	n/a	n/a	n/a	O	n/a
Adjustment Information							
Waiting Time Adjustment (First Seen)	M*	n/a	n/a	O*	n/a	n/a	n/a
Waiting Time Adjustment Reason (First Seen)	M*	n/a	n/a	O*	n/a	n/a	n/a
Waiting Time Adjustment (Treatment)	n/a	M*	M*	M*	M*	M*	M*
Waiting Time Adjustment Reason (Treatment)	n/a	M*	M*	M*	M*	M*	M*
Breach Information							
Delay Reason Referral to First Seen (Cancer or Breast Symptoms)	M*	n/a	n/a	n/a	n/a	n/a	n/a
Delay Reason Comment (First Seen)	M*	n/a	n/a	n/a	n/a	n/a	n/a
Delay Reason (Decision to Treat)	n/a	M*	M*	M*	M*	M*	M*
Delay Reason Comment (Decision to Treat)	n/a	M*	M*	M*	M*	M*	M*
Delay Reason Referral to Treatment (Cancer)	n/a	M*	n/a	M*	/a	O*	n/a
Delay Reason Comment (Referral to Treatment)	n/a	M*	n/a	M*	n/a	O*	n/a
Delay Reason (Consultant Upgrade)	n/a	M*	n/a	M*	n/a	O*	n/a
Delay Reason Comment (Consultant Upgrade)	n/a	M*	n/a	M*	n/a	O*	n/a
Other Information							
Multidisciplinary Team Discussion Indicator	M*	M*	M*	M*	M*	M*	M*
Multidisciplinary Team Discussion Date (Cancer)	M*	M*	M*	M*	M*	M*	M*

11.1 Patient Information

11.1.1 NHS NUMBER

This is the 10 digit numeric number used to identify a patient uniquely within the NHS in England and Wales. It is a unique identifier for a patient and will not vary by any organisation of which a person is a patient.

11.1.2 What is the policy for a patient with no NHS number eg servicemen, prisoners and mobile populations such as non-UK citizens?

A patient with no NHS number should still be treated as clinically appropriate within the waits commitments but it will not be possible to upload related data on to the [CWT-Db](#). NHS England expect there to be a certain proportion of such patients that data cannot be collected for.

11.1.3 NHS NUMBER STATUS IDENTIFIER CODE

A Two digit numerical code used as a validation for the NHS NUMBER.

Options:

- 01 Number present and verified
- 02 Number present but not traced
- 03 Trace required
- 04 Trace attempted - No match or multiple match found
- 05 Trace needs to be resolved - (NHS Number or Patient detail conflict)
- 06 Trace in progress
- 07 Number not present and trace not required
- 08 Trace postponed (baby under six weeks old)

11.1.4 PATIENT PATHWAY IDENTIFIER (PPI)

This is an identifier that is unique to a patient for a particular condition. It consists of a 20 digit alphanumeric figure which, together with the organisation code of the issuer, uniquely identifies a patient pathway for the length of a particular condition. The PPI is allocated by the organisation receiving the referral request which would result in the patient being seen for the first time for a particular condition/suspected condition.

The PPI should be the same as the one used for [RTI](#) and needs to be consistent across all provider systems.

The PPI needs to be unique within an organisation.

In the rare case where two organisations submit the same PPI the [ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) will differentiate between the two records.

There are no restrictions to the format of the PPI although spaces are not recommended as they can produce problems on some NHS systems.

11.1.5 **Can a patient have multiple patient pathway identifiers (PPI)?**

Once created the same PPI should be used for every recording of an individual condition for the entire lifetime of the patient and so a PPI could cover multiple episodes of care.

If a patient has multiple conditions then these would each get their own individual PPI.

11.1.6 **How is the PPI generated for patients coming through the NHS e-Referral Service route?**

In this case the PPI is made up of two parts. The first part is 8 packing characters (X09UBRN=), the second part is the unique booking reference number (converted) which is a 12 digit non alpha-numeric number. The packing characters are there to increase the Unique Reference Booking Number up to 20 characters so that it is accepted in the cancer waiting times database.

11.1.7 **How do we create a PPI for patients that come through A&E?**

It is assumed that a patient coming through A&E and diagnosed with cancer or a suspicion of cancer would be referred on to an elective pathway from A&E (eg following stabilisation) or admitted for assessment then referred internally within the provider to the relevant [MDT](#). They should receive a PPI at the point of the referral to the cancer service. The same principle applies on [RTT](#) pathways for other acute services, for example, patients admitted with heart problems.

On the rare occasion where first treatment does take place following an emergency admission (eg at the time of emergency bowel surgery) a PPI would not be available related to this episode (ie where the patient is first treated) and therefore cannot be entered. As such the [CWT-Db](#) system validation will allow you to enter a record without a PPI.

If a patient is admitted as an emergency prior to a planned first appointment for suspicion of cancer then the [PPI](#) generated from the original referral on to the elective pathway should be used.

11.1.8 **If a patient has been diagnosed and treated for a cancer and reported under a relevant PPI and then is referred in again with a suspected second primary to another site this patient will have a new PPI. If the new referral is subsequently diagnosed as a recurrence rather than a new primary cancer (eg colorectal patients who develop lung mets) what should we do?**

You should try to link back to the original PPI if you find that a suspected second primary cancer is in fact a recurrence linked to the initial primary cancer, ie retrospectively change the record to ensure it links to the original PPI.

However, we need to be pragmatic. If it would take a disproportionate amount of work/time to retrospectively change the PPI on local systems then it is acceptable to keep the new PPI albeit not strictly speaking correct.

- 11.1.9 If a patient is referred urgently for suspected cancer by their GP and no cancer is diagnosed, then is re-referred in six months' time for suspected cancer at the same site (eg a breast patient initially diagnosed with cysts) should the same PPI be used or would a new one be appropriate?**

If the patient was initially referred with a suspected breast cancer - they would have a unique identifier for that referral even if the referral ended with a non-cancer diagnosis (ie cysts). If they were then re-referred at a later date, and the referral was linked to the initial referral, ie cancer was once again suspected then this would come under the same [PPI](#) unless:

- the second referral was unrelated to the initial symptoms and/or diagnosis (this would then have a new identifier); or
- the patient had been formally given a benign diagnosis following the earlier pathway (this would also have a new identifier).

- 11.1.10 Will records uploaded without a PPI be rejected by the CWT-Db?**

Records uploaded without a PPI will not be rejected. However, the PPI is a mandatory field within the [CWT](#) dataset if applicable to the episode of care. All mandatory fields are expected to be completed where applicable on the database by the end of the 25th working day after the end of a month or quarter.

11.2 Provider Information

- 11.2.1 ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)**

This is the code of the organisation issuing the Patient Pathway Identifier (PPI) ie the organisation that receives the referral request resulting in the patient being seen for the first time for a particular condition/suspected condition.

It is the use of this organisation code, along with the 20 digit PPI that creates a unique reference number for a patient pathway and any timed periods it contains.

Where the NHS e-Referral Service has been used the Code X09 should be used.

- 11.2.2 SITE CODE (OF PROVIDER CONSULTANT UPGRADE)**

This is the Site Code of the organisation acting as a commissioned health care provider when a decision is made to upgrade the patient from the [RTT](#) pathway to the 62 day standard ie it is the Site Code of the organisation where a 62 day period for the consultant upgrade standard starts.

- 11.2.3 SITE CODE (PROVIDER FIRST SEEN)**

This is the Site Code of the organisation acting as a commissioned health care provider where the patient is first seen (where the [DATE FIRST SEEN](#)

would be recorded) ie where the end point of the two week wait period takes place.

11.2.4 **SITE CODE (PROVIDER DECISION TO TREAT (CANCER))**

This is the Site Code of the organisation acting as a commissioned health care provider where the decision to treat the patient (the starting point for the 31 day period for first treatments and for some subsequent treatments) was made – the [CANCER TREATMENT PERIOD START DATE](#).

11.2.5 **SITE CODE (PROVIDER TREATMENT START DATE (CANCER))**

This is the Site Code of the organisation acting as commissioned health care provider where a patient receives a treatment which ends a 62 and/or 31 day period(s) ie the organisation where the [TREATMENT START DATE \(CANCER\)](#) takes place.

11.3 **Date Information**

11.3.1 **CANCER REFERRAL TO TREATMENT PERIOD START DATE**

This is the starting point for the two week and 62 day standards. It will be one of the following:

- receipt of referral direct from GP (GMP, GDP or Optometrist) (original referral request received date) – for two week wait referrals for suspected cancer and two week wait referrals for patients with breast symptoms (cancer not suspected)
- receipt of referral direct from any health professional (original referral request received date) – for two week wait referrals for patients with breast symptoms (cancer not suspected)
- receipt of referral via Choose & Book UBRN conversion - the Unique Booking Reference Number conversion date for an appointment – for two week wait referrals for suspected cancer and two week wait referrals for patients with breast symptoms (cancer not suspected)
- receipt of referral for further assessment following a suspicious mammogram (recorded as original referral request received date) – this is for patients coming in via urgent referral from the breast screening programme with suspected cancer
- receipt of referral for an appointment with a specialist screening practitioner (SSP) to discuss suitability for colonoscopy (recorded as original referral request received date) – this is for patients coming in via urgent referral from the bowel screening programme with suspected cancer
- receipt of referral for a colposcopy appointment (recorded as original referral request received date or [UBRN](#) conversion) – this is for patients coming in via urgent referral from the cervical screening programme with moderate or worse cytology.

11.3.2 CONSULTANT UPGRADE DATE

This is the date that the consultant responsible for the care of the patient (or an authorised member of the consultant team - as defined by local policy) decided that the patient should be upgraded from a [RTT](#) period to a 62 day period as cancer is suspected.

These dates should be uploaded retrospectively by the provider delivering the treatment. It is for local policies to determine processes to facilitate this. If a patient is upgraded but cancer is not diagnosed then there is no national requirement to collect this information but local collection would aid local awareness and education about the magnitude and appropriateness of upgrades.

11.3.3 What referrals can and can't be upgraded?

Referrals that can be upgraded are:

- any routine referrals (ie [PRIORITY TYPE CODE '1'](#))
- urgent referrals that are not from the NHS cancer screening programmes (ie [PRIORITY TYPE CODE '2'](#)).

Referrals that cannot be upgraded are:

- two week wait referrals for suspected cancer (PRIORITY TYPE CODE '3')
- two week wait referrals for breast symptoms (cancer not suspected) (PRIORITY TYPE CODE '3')
- urgent screening referrals (PRIORITY TYPE CODE '2') – these referrals can be identified by data item [SOURCE OF REFERRAL FOR OUT-PATIENTS](#) Code '17' which is for a referral from a NHS cancer screening programme.

These are exceptions because the patient would automatically be covered by the 62 day standard if cancer was diagnosed.

11.3.4 Is there a time after which an upgrade is not allowed?

Yes. An upgrade must be on or before:

- a Decision to Treat with a patient has been agreed (ie before the decision to treat date recorded as the [CANCER TREATMENT PERIOD START DATE](#))
- the multidisciplinary team meeting where the care plan that was subsequently agreed with the patient was discussed ie the [MULTIDISCIPLINARY TEAM DISCUSSION DATE \(CANCER\)](#) (if the patient is discussed at a MDT meeting).

11.3.5 Why not start the 62 day period for a consultant upgrade with receipt of the upgrade given that the other 62 day periods start at the receipt of a referral?

There is no formal process by which the receipt of an upgrade could be measured ie it is not like the receipt of a referral for an appointment which would be generated by a service request. The decision has therefore been taken that the date of the decision to upgrade ([CONSULTANT UPGRADE DATE](#)) should start the process as local systems could be introduced to capture this date.

11.3.6 Why not start the 62 period for a consultant upgrade with receipt of the original referral which the consultant went on to upgrade?

At the point the original referral is received (recorded as the [REFERRAL TO TREATMENT PERIOD START DATE](#) for the RTT pathways) cancer is not suspected and it might be a few weeks before a consultant (or authorised member of a consultant team) decides to upgrade the patient onto a faster pathway. It is not appropriate to calculate a timed 62 day period from this point (ie retrospectively starting the clock from the original referral) as the patient was not on a faster pathway at that point.

11.3.7 DATE FIRST SEEN

This is the date when the patient is seen for the first time by a consultant (or member of their team) or in a clinic following the referral receipt.

It will be one of the following (whichever is the earliest service relating to the referral request):

- first out-patient appointment - this is the attendance date with a consultant or member of the consultant team
- first diagnostic procedure (if this precedes the first out-patient appointment) eg CT scan prior to appointment with chest physician ie straight to test
- first appointment following referral (or recall) from (or by) a screening provider ie
 - breast - appointment for further assessment following screening mammogram
 - bowel - appointment with a specialist screening practitioner to discuss suitability for colonoscopy
 - cervical - appointment for colposcopy.
- first seen as an emergency – this is the start date of the Hospital Provider Spell or the Arrival Date of the Accident And Emergency Attendance. If a patient is admitted as an emergency for the same condition they have been referred under the two week wait standard for but have yet to have their first seen date, this admission would count as the DATE FIRST SEEN. The patient would no longer be counted as part of the two week wait cohort. This patient could be upgraded onto

the 62 day period if a consultant (or authorised member of the team) suspected cancer.

11.3.8 **CANCER TREATMENT PERIOD START DATE**

This is the date that marks the start of the 31 day period for both first and subsequent treatments. It will be either the DECISION TO TREAT DATE (DTT) or the EARLIEST CLINICALLY APPROPRIATE DATE (ECAD).

11.3.9 **TREATMENT START DATE (CANCER)**

This is the start date of the first or subsequent cancer treatments and marks the end of the 62 day period and the end of the 31 day period for first or subsequent treatments.

11.3.10 **REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)**

The 'REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)' is the date of the last transfer of a patient to the provider that starts the first definitive treatment.

This field is populated by the date in the local patient administration service with the same name. For any patient who during their cancer care sees two or more providers, this field should be populated. If the patient goes to more than two providers this field is only populated with the last transfer to the provider starting the first definitive treatment. Some example scenarios are shown:

Example 1: Patient referred to Provider A. The patient has their first outpatient appointment with a consultant, is diagnosed and treated at Provider A. The 'REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)' is left blank.

Example 2: Patient referred to Provider A. The patient has their first outpatient appointment with a consultant and is diagnosed at Provider A. A decision to refer the patient to Provider B is made on the 1st April. The referral letter/request is sent on the 2nd April. Provider B receives the referral letter/request on the 3rd April. The patient is admitted for treatment on the 7th April at Provider B. Finally the patient is given a first definitive treatment on the 25th April at Provider B. The 'REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)' is sent to the 3rd April by Provider B.

Example 3: Patient referred to Provider A. The patient has their first outpatient appointment at Provider A but is then referred to Provider B. Provider B then performs diagnostic tests before referring the patient back to Provider A. Provider A then diagnoses the patient and refers them to Provider C. Provider C receives the referral request on the 3rd April. Provider C goes on to start a first definitive treatment. The 'REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)' is sent to the 3rd April by Provider C.

11.3.11 Who is responsible for completing this field?

The responsibility for completion of this field is with the provider starting the first definitive treatment. If the referring provider disagrees with the date the treating provider submits then they should firstly contact the treating provider to see if there has been a mistake.

11.4 Cancer Information

11.4.1 TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE

This data item is used to record the site where cancer is suspected by the GP, GDP or Optometrist referring the patient as a two week wait. It is also used to identify patients being referred on the basis of exhibited (non-cancer) breast symptoms from any healthcare professional.

Options

- 01 Suspected breast cancer
- 02 Suspected children's cancer
- 03 Suspected lung cancer
- 04 Suspected haematological malignancies excluding acute leukaemia
- 05 Suspected acute leukaemia
- 06 Suspected upper gastrointestinal cancers
- 07 Suspected lower gastrointestinal cancers
- 08 Suspected skin cancers
- 09 Suspected gynaecological cancers
- 10 Suspected brain or central nervous system tumours
- 11 Suspected urological cancers (excluding testicular)
- 12 Suspected testicular cancer
- 13 Suspected head and neck cancers
- 14 Suspected sarcomas
- 15 Other suspected cancer
- 16 Exhibited (non-cancer) breast symptoms - cancer not initially suspected

Codes 01 to 15 should only be used for two week wait referrals from GPs (GMP, GDP or Optometrist) for suspected cancer. Code 16 is not restricted to two week wait referrals from a GP (GMP, GDP or Optometrist); these can be from any source.

11.4.2 When should Code 01 and Code 16 be used ie how do we distinguish between suspected and non-suspected breast cancer?

Code 01 is used for GP referrals for suspected breast cancer. Code 16 is only to be used for referrals of patients with breast symptoms where cancer is not suspected. Any relevant health professional can make a referral under code 16.

The distinction between suspected breast cancer and exhibited (non-cancer) symptoms is necessary to support the monitoring of the NHS Operating Framework 2011-12. The differentiation might also help to monitor

appropriateness of referrals and therefore identify any education needed about signs and symptoms of breast cancer amongst relevant healthcare professionals.

11.4.3 **PRIMARY DIAGNOSIS (ICD)**

This data item is used to record a four figure ICD-10 diagnosis of the primary tumour ie the code which identifies the type of cancer. The codes which the CWT-Db will accept can be found at

<http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation>.

11.4.4 **How do we code secondary, metastatic disease or an unknown primary?**

For any recurrent or metastatic disease the ICD-10 code of the primary site (rather than the metastatic site) needs to be recorded as the PRIMARY DIAGNOSIS.

If you are treating metastatic disease of an unknown primary you would use codes C78.0 - C79.8 as relevant to the metastatic site you are treating.

If you are treating the unknown primary (eg with palliative treatment) you would use code C80 which is for malignant neoplasm without specification of site. If at a later date the primary is identified then there is no need to update the ICD-10 code of the record. The correct ICD10 code can be used for any 31 day subsequent treatments that follow. You may wish to update records submitted to cancer registries.

11.4.5 **TUMOUR LATERALITY**

This identifies the position of a tumour within a patient.

Options

- L Left
- R Right
- M Midline
- B Bilateral
- 8 Not applicable
- 9 Not known

11.4.6 **METASTATIC SITE**

This data item is used where the primary cancer has spread elsewhere in the body – it identifies the site of the metastatic disease ie to where a primary cancer has spread.

Options

- 02 Brain
- 03 Liver
- 04 Lung
- 06 Multiple metastatic sites
- 08 Skin
- 09 Distant lymph nodes

- 10 Bone
- 11 Bone marrow
- 07 Unknown metastatic site
- 99 Other metastatic site

You should record the site of the primary diagnosis (if known) in the [PRIMARY DIAGNOSIS](#) field using the [ICD-10](#) code and record in the [METASTATIC SITE](#) field the actual site of the metastases (ie you do not use the ICD-10 code for the metastases itself).

You are only required to fill in the metastatic site for a first treatment when treating an unknown primary.

11.4.7 Why can't the details of the metastatic site be included within the treatment record of the primary cancer?

We are aware that the first treatment record will not include the metastatic details. If metastatic details were included on the record for a known primary it would not be clear if the treatment being reported on the CWT-Db was for the first treatment of the primary or for treatment of the metastases.

11.4.8 A patient could be diagnosed with a primary and metastatic cancer at the same time – how should this be recorded?

Treatment of metastatic disease has to be classed as a subsequent treatment if the primary is known. The 31 day subsequent treatment of the metastatic disease is a separate record. It can be uploaded before the 31 day first treatment record for the primary has been uploaded as treatments do not need to be uploaded sequentially. If the patient needs the treatment for the metastatic disease BEFORE the treatment of the primary cancer you can upload a 31 day subsequent treatment record even though it took place ahead of the first treatment but if the patient is on a 62 day pathway for the primary cancer that subsequent treatment would NOT stop the 62 day clock. Thus, for first treatment of a primary you don't include the metastatic site. However, a 31 day subsequent treatment record related to the metastatic site could be uploaded if a treatment was delivered.

11.4.9 What happens if a primary cancer is diagnosed and confirmed AFTER a metastases has been treated?

If the primary cancer had not been diagnosed before a treatment was given you would have been treating metastases of an unknown primary which CAN be classed as first definitive treatment. If the primary cancer is diagnosed at a later date the [ICD-10](#) code can be included for any subsequent treatments.

11.5 Treatment Information

11.5.1 CANCER TREATMENT MODALITY

This data item identifies the type of treatment or care that a patient receives within the episode that ends a 31 or 62 day period. The modality codes need to be used for both first and subsequent treatments.

Options

- 01 Surgery
- 02 Anti-cancer drug regimen (Cytotoxic Chemotherapy)
- 03 Anti-cancer drug regimen (Hormone Therapy)
- 04 Chemoradiotherapy
- 05 Teletherapy (Beam Radiation excluding Proton Therapy)
- 06 Brachytherapy
- 07 Specialist Palliative Care
- 08 Active Monitoring (excluding non-specialist Palliative Care)
- 09 Non-specialist Palliative Care (excluding Active Monitoring)
- 10 Radio Frequency Ablation (RFA)
- 11 High Intensity Focussed Ultrasound (HIFU)
- 12 Cryotherapy
- 13 Proton Therapy
- 14 Anti-cancer drug regimen (other)
- 15 Anti-cancer drug regimen (Immunotherapy)
- 16 Light Therapy (including Photodynamic Therapy and Psoralen and Ultraviolet A Therapy (PUVA))
- 17 Hyperbaric Oxygen Therapy
- 19 Radioisotope Therapy (including Radioiodine)
- 20 Laser Treatment (including Argon Beam therapy)
- 21 Biological Therapies (excluding Immunotherapy)
- 22 Radiosurgery
- 23 Other Treatment
- 98 All treatment declined

11.5.2 CANCER CARE SETTING (TREATMENT)

This data item is used to record the type of care setting where the cancer treatment took place that marks the end of the 31 and/or 62 day period (ie the [TREATMENT START DATE \(CANCER\)](#)).

It is necessary to know the type of admission as the waiting time adjustment for declining a treatment can only be applied to admitted treatments. In addition, knowing the care setting for treatment could support local capacity planning.

Options

- 01 Cancer treatment delivered as part of a Hospital Provider Spell (where patient classification is National code 1 – Ordinary admission)
- 02 Cancer treatment delivered as part of a Hospital Provider Spell (where patient classification is National Code 2 - Day case admission)
- 03 Cancer treatment delivered in an Out-patient setting

04 Cancer treatment delivered in another care setting
 99 Setting Unknown

11.5.3 CLINICAL TRIAL INDICATOR

This data item is used to record whether the treatment package recorded under [CANCER TREATMENT MODALITY](#) was part of a clinical trial of a new treatment (eg drug or procedure).

Options

01 Patient is taking part in a clinical trial
 02 Patient is not taking part in a clinical trial
 99 Unknown

If the clinical trial relates to a part of the pathway other than the treatment episode then code '02' should be used.

11.5.4 RADIOTHERAPY PRIORITY

This data item is used to record the priority for a Radiotherapy Treatment Course identified by the requesting clinician and is also included in the Radiotherapy Dataset (RTDS).

This data item, in conjunction with the data item [RADIOTHERAPY INTENT](#), has been included to enable the Royal College of Radiologists (RCR) to continue to undertake their radiotherapy waiting times audit, based on RCR Guidance, which has different parameters from those used for cancer waits.

Options

E - Emergency (treatment required within 24 hours)
 R - Routine
 D - Elective delay (treatment delayed for clinical reasons)

11.5.5 What should be classed as: RT Priority - "D" - elective delay (treatment delayed for clinical reasons)?

This may be a patient who is too ill to start their radiotherapy due to, for example, concurrent cardiac problems which need to be treated first.

11.5.6 RADIOTHERAPY INTENT

This data item is used to record the intent of the radiotherapy treatment ie to see if it is being used to actively treat the cancer or to palliate symptoms or for some other reason.

This data item, in conjunction with the data item [RADIOTHERAPY PRIORITY](#), has been included to enable the [RCR](#) to continue to undertake their radiotherapy waiting times audit, based on RCR Guidance, which has different parameters from those used for cancer waits.

Options

01 Palliative (ie for symptom control)

- 02 Anti-cancer (ie treatment which aims to be curative - including adjuvant)
- 03 Other

11.5.7 **SOURCE OF REFERRAL FOR OUT-PATIENTS**

This data item identifies the source of referral for the consultant-led out-patient episode which would generally be the [DATE FIRST SEEN](#) for the patient unless they went to a diagnostic clinic first. It can be initiated by a range of health professionals although an urgent two week wait referral has to be initiated by a GP (GMP, GDP or Optometrist).

This data item is not applicable for subsequent treatments.

Options

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode.

- 01 following an emergency admission
- 02 following a Domiciliary Consultation
- 10 following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)
- 11 other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode.

- 03 referral from a GENERAL MEDICAL PRACTITIONER
- 92 referral from a GENERAL DENTAL PRACTITIONER
- 12 referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)
- 04 referral from an Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)
- 05 referral from a CONSULTANT, other than in an Accident and Emergency Department
- 06 self-referral
- 07 referral from a Prosthetist
- 13 referral from a Specialist NURSE (Secondary Care)
- 14 referral from an Allied Health Professional
- 15 referral from an OPTOMETRIST
- 16 referral from an Orthoptist
- 17 referral from a NHS cancer screening programme
- 93 referral from a Community Dental Service
- 97 other - not initiated by the CONSULTANT responsible for the Consultant Out Patient Episode

11.5.8 **Does this have to be completed for every referral for an out-patient appointment a patient receives for a particular cancer?**

Within the [CWT-Db](#) upload of this data item is only required for the first referral by the NHS to a provider that initiates a cancer referral to treatment period and results in a [DATE FIRST SEEN](#).

11.5.9 **How do we code referrals made by specialist nurses in primary care?**

Such referrals are made under the authority of the General Medical Practitioner leading their team and should therefore be classified as referrals from the GP (GMP, GDP or Optometrist) (ie Code '03'). Referrals from Specialist Nurses in Secondary Care should be classified as code '13'.

11.5.10 **PRIORITY TYPE CODE**

This data item identifies the priority of a referral. This data item is not applicable for subsequent treatments.

Options

- 3 this is for two week wait referrals for suspected cancer and two week wait referrals for patients with breast symptoms (cancer not suspected);
- 2 this is for urgent referrals – this would include urgent screening referrals coming on to the 62 day pathway
- 1 this is for routine referrals.

11.5.11 **Which of these priority type codes can be upgraded on to the 62 day pathway?**

- Priority '3' (two week wait referrals) - this will cover urgent GP (GMP, GDP or Optometrist) referrals for suspected cancer and referrals for breast symptoms (cancer not suspected) - both sets of patients automatically go on to 62 day pathway if cancer is diagnosed so patients referred under this priority type code do not need to be upgraded
- Priority '2' (urgent referrals) - for cancer standards this would be used for patients coming on to 62 day pathway from screening programmes. An upgrade is not needed for these patients. Patients with this referral code not from cancer screening services could be upgraded on to the 62 day pathway if a clinician suspects cancer and a local protocol to upgrade is in place
- Priority '1' (routine referrals) - for cancer standards any patient routinely referred could be upgraded to be covered by the 62 day standard if a clinician suspects cancer and a local protocol to upgrade is in place.

In terms of the upgrade, patients with a PRIORITY TYPE CODE of either '1' (routine) or '2' (urgent - but not from screening programmes) could be upgraded onto the 62 day pathway if a clinician suspects cancer and a local protocol to upgrade is in place. Without the upgrade the patient would be on the [RTT](#) pathway.

11.5.12 **If urgent referrals (not from screening programmes) or routine referrals are upgraded, should their PRIORITY TYPE CODE be changed to PRIORITY TYPE CODE '3' (ie equivalent to two week wait)?**

The [PRIORITY TYPE CODE](#) is that which relates to the initial referral.

11.5.13 **CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS**

This data item enables local tracking of the status of patients referred with a suspected cancer (via GP/GDP/Optometrlist or screening service) or referred from any health professional with breast symptoms where cancer was not suspected or upgraded onto the 62 day period.

Options

- 14 Suspected primary cancer
- 09 Under investigation following symptomatic referral, cancer not suspected (breast referrals only) - this code can only be used for two week wait symptomatic breast referrals ie those with a [TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE](#) of Code '16' – Exhibited (non-cancer) breast symptoms - cancer not initially suspected)
- 03 No new cancer diagnosis identified by the Healthcare Provider
- 10 Diagnosis of new cancer confirmed - first treatment not yet planned
- 11 Diagnosis of new cancer confirmed - English NHS first treatment planned
- 07 Diagnosis of cancer confirmed - no English NHS treatment planned
- 08 First treatment commenced (English NHS only)
- 12 Diagnosis of new cancer confirmed - subsequent treatment not yet planned
- 13 Diagnosis of new cancer confirmed - subsequent English NHS treatment planned
- 21 Subsequent treatment commenced (English NHS only)
- 15 Suspected recurrent cancer
- 16 Diagnosis of recurrent cancer confirmed - first treatment not yet planned
- 17 Diagnosis of recurrent cancer confirmed - English NHS first treatment planned
- 18 Diagnosis of recurrent cancer confirmed - no English NHS treatment planned
- 19 Diagnosis of recurrent cancer confirmed - subsequent treatment not yet planned
- 20 Diagnosis of recurrent cancer confirmed - subsequent English NHS treatment planned

11.5.14 **Do these codes need to be updated throughout the patient journey?**

It is mandatory to complete this field at the point of [DATE FIRST SEEN](#) and also at the [TREATMENT START DATE \(CANCER\)](#) and it is likely that the code will need to change at the second of these points, for example, changing from Code '14' (suspected primary cancer) to Code '08' (first treatment commenced). You might wish to update the codes more frequently locally to aid local tracking and record management – this might be particularly useful where Inter-Provider Transfers take place or to identify when records can be closed eg when cancer is ruled out (Code '03').

11.5.15 **How are recurrent/metastatic cancers recorded?**

Code '21' can be used for recurrent/metastatic cancers as well as subsequent treatments for a new cancer.

If a suspected recurrent cancer is ruled out then code '03' can be used.

11.5.16 All treatments for recurrences are counted as a subsequent treatment but codes 16 and 17 allow you to record first treatments for these recurrences – why is that?

For local planning purposes you might wish to record that the first treatment for the recurrence is being planned. For the national standard, treatment of a recurrence, when given, is always assumed to be a subsequent treatment on the basis that the patient would have had some form of treatment for their initial cancer even if that was some years ago.

11.5.17 CANCER TREATMENT EVENT TYPE

This identifies the phase a treatment has reached during a cancer patient pathway for primary, recurrent or metastatic cancer.

Options

- 01 First Definitive Treatment for a new primary cancer
- 02 Second or subsequent treatment for a new primary cancer
- 03 Treatment for a local recurrence of a primary cancer
- 04 Treatment for a regional recurrence of cancer
- 05 Treatment for a distant recurrence of cancer (metastatic disease)
- 06 Treatment for multiple recurrences of cancer (local and/or regional and/or distant)
- 07 First treatment for metastatic disease following an unknown primary
- 08 Second or subsequent treatment for metastatic disease following an unknown primary
- 09 Treatment for relapse of primary cancer (second or subsequent)
- 10 Treatment for progression of primary cancer (second or subsequent)

11.5.18 Which of these codes are for first treatments that can end a 62 day period?

Only codes '01' and '07' will be considered to be first treatment events and therefore suitable for reporting as the end points to the 62 day period (from urgent GP (GMP, GDP or Optometrist) referral, referral with breast symptoms where cancer is not suspected, urgent referral from screening programmes or consultant upgrades) and against the original 31 day standard for first treatment.

11.5.19 What is code '06' (Treatment for multiple recurrences of cancer (local and/or regional and/or distant)) used for?

This is for a patient who is treated for a cancer which has spread in more than one way.

- Local would be a recurrence very close to the site of the original primary cancer
- Regional would be, for example in the case of a breast patient, spread to the axilla, supraclavicular or inter-mammary nodes
- Distant would be metastatic spread to somewhere like the liver, brain or lungs.

11.5.20 What are code '09' (Treatment for relapse of primary cancer (second or subsequent)) and code '10' (Treatment for progression of primary cancer (second or subsequent)) used for?

As haematological cancers do not spread/recur in the same way as solid tumours, haematologists consulted about cancer waits advised including this description within the coding structure.

11.5.21 This item seems similar to Cancer or Symptomatic Breast Referral Patient Status – what is the difference/why do we need both?

- This item ([CANCER TREATMENT EVENT TYPE](#)) is about reporting the final event that would mark the end of a 62 day and/or 31 day period;
- The [CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS](#) item is for local tracking and record management.

11.5.22 DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)

This is the date on which:

- a GP, GDP or Optometrist decides to refer a patient urgently to secondary care with suspected cancer
- any health professional decides to make a referral to secondary care for breast symptoms where cancer is not suspected
- a screening service decides to urgently refer a patient with suspected cancer
- a consultant decides to upgrade.

11.5.23 How do we get this date?

This date may be, for example:

- the date on the letter, proforma or email from the general medical practitioner, general dental practitioner or other health professional
- the appointment date of the first out-patient appointment, if the referral was a self-referral
- the date on the letter for patients recalled for further assessment following a routine screening programme appointment.

The date may not be available to the health care provider if the initial service request to secondary care was made via the e-Referral Service system and no supporting information was received.

11.6 Adjustment Information

11.6.1 WAITING TIME ADJUSTMENT (FIRST SEEN)

This records the number of days that should be removed from the calculated waiting time for the two week wait period and potentially the 62 day period (if cancer is confirmed) – ie between receipt of the referral or decision of

consultant upgrade (recorded as [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) or [CONSULTANT UPGRADE DATE](#)) and the [DATE FIRST SEEN](#).

11.6.2 WAITING TIME ADJUSTMENT REASON (FIRST SEEN)

This data item is where you record the reason for using an adjustment prior to the first seen date.

Options

9 No adjustment to waiting time

3 [DNA](#)

11.6.3 Why do we need to select an option that no adjustment was used?

If no figure has been entered in the WAITING TIME ADJUSTMENT (FIRST SEEN) it is obvious no adjustment has been made.

If you enter a '0' in the [WAITING TIME ADJUSTMENT \(FIRST SEEN\)](#) field then you need to enter Code '9' in this field. However, you can choose to leave both fields blank if you prefer. The option to include a '0' and then Code '9' has been included because some local systems find it easier to output zeros than blanks.

11.6.4 WAITING TIME ADJUSTMENT (TREATMENT)

This data item is used to record the number of days that should be removed from the calculated waiting time between the [CANCER TREATMENT PERIOD START DATE](#) and the [TREATMENT START DATE \(CANCER\)](#) ie the number of days that a clock can be paused for a 31 or 62 day period if a reasonable offer of treatment in admitted care has been declined.

11.6.5 WAITING TIME ADJUSTMENT REASON (TREATMENT)

This data item is where you record the reason for using an adjustment prior to admitted care.

There are validation rules in the [CWT-Db](#) to ensure that adjustments are not used for non-admitted care.

Options

9 No adjustment to waiting time

8 Patient Pause

11.6.6 Why do we need to select an option that no adjustment was used if no figure has been entered in the WAITING TIME ADJUSTMENT (TREATMENT) it is obvious no adjustment has been made.

If you enter a '0' in the [WAITING TIME ADJUSTMENT \(TREATMENT\)](#) field then you need to enter Code '9' in this field. However, you can choose to leave both fields blank if you prefer. The option to include a '0' and then Code '9' has been included because some local systems find it easier to output zeros than blanks.

11.7 Breach Information

11.7.1 DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the two week period ie why the health care provider was unable to provide an appointment within the service standard of two weeks. This reason will also be applicable if the patient went on to breach the related 62 day standard.

Options:

- 01 Clinic cancellation
- 02 Out-patient capacity inadequate (ie no cancelled clinic, but not enough slots for this patient)
- 03 Administrative delays
- 05 Patient unavailable (the patient has declined the opportunity to be seen within two weeks prior to any appointment being offered)
- 06 Patient declines (the patient declines all appointments offered within two weeks)
- 07 Patient cancellation (the patient cancels their booked appointment)
- 08 Patient care not commissioned by the English NHS (waiting time standard does not apply)
- 98 Other reason

11.7.2 What option do we pick if there are multiple reasons for a breach?

You should pick the option that accounted for the largest proportion of the breach.

11.7.3 What do we do if patient choice is the reason for a delay?

Use code 98 'other reason' and use the related comment field ([DELAY REASON COMMENT \(FIRST SEEN\)](#)) to describe the problem in more detail.

11.7.4 DELAY REASON COMMENT (FIRST SEEN)

This is the free text comment field to describe in more detail why the maximum two week wait period (and potentially the 62 day period also) has been breached. It should not include the name of the patient, any other personal details or the clinician(s) involved in the case.

11.7.5 DELAY REASON (DECISION TO TREATMENT)

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the 31 day periods ie why the health care provider was unable to provide the treatment in question within the service standard of 31 days.

Options

Delays relating to diagnostic and pre-treatment events

- 01 Clinic cancellation
- 02 Out-patient capacity inadequate (ie no cancelled clinic, but not enough slots for this patient)
- 03 Administrative delay (eg failed to be rebooked after Did Not Attend, lost referral)
- 07 Complex diagnostic pathway (many, or complex, diagnostic tests required)
- 11 Diagnosis delayed due for medical reasons (patient unfit for diagnostic episode, excluding planned recovery period following an invasive diagnostic test)
- 13 Delay due to recovery after an invasive test (patient diagnosis or treatment delayed due to planned recovery period following an invasive diagnostic test)
- 17 Patient choice delay relating to first outpatient appointment
- 18 Health Care Provider initiated delay to diagnostic test or treatment planning
- 19 Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given
- 20 Patient Did Not Attend an appointment for a diagnostic test or treatment planning event (no advance notice)
- 98 Other reason

Delays relating to treatment in an admitted care setting

- 04 Elective cancellation (for non-medical reason)
- 05 Elective capacity inadequate (patient unable to be scheduled for treatment within standard time)
- 10 Treatment delayed for medical reasons (patient unfit for treatment episode, excluding planned recovery period following diagnostic test)
- 21 Patient failed to present for elective treatment (choice)
- 22 Patient care not commissioned by the English NHS (waiting time standard does not apply)
- 98 Other reason

Delays relating to treatment in a non-admitted care setting

- 01 Clinic cancellation
- 02 Out-patient capacity inadequate (ie no cancelled clinic, but not enough slots for this patient)
- 10 Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)
- 14 Patient Did Not Attend treatment appointment
- 16 Patient Choice (patient declined or cancelled an offered appointment date for treatment)
- 22 Patient care not commissioned by the English NHS (waiting time standard does not apply)
- 98 Other reason

11.7.6 What option do we pick if there are multiple reasons for a breach?

You should pick the option that accounted for the largest proportion of the breach.

11.7.7 What do we do if patient choice is the reason for a delay?

Use code '98' "other reason" and use the related comment field ([DELAY REASON COMMENT \(DECISION TO TREATMENT\)](#)) to describe the problem in more detail.

11.7.8 DELAY REASON COMMENT (DECISION TO TREATMENT)

This is the free text comment field to describe why the maximum 31 day period has been breached. It should not include the name of the patient, any other personal details or the clinician(s) involved in the case.

11.7.9 DELAY REASON REFERRAL TO TREATMENT (CANCER)

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the 62 day period ie why the health care provider was unable to provide treatment within the service standard of 62 days.

Options - See options for [DELAY REASON \(DECISION TO TREATMENT\)](#).

11.7.10 Are all 62 day standard breaches recorded using this field?

It is for any breach of a 62 day period starting from:

- receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer
- receipt of urgent referral from any healthcare professional for breast symptoms (cancer not suspected)
- receipt of urgent referral from screening programmes (breast, bowel or cervical).

It is not to be used for breaches of the 62 day period following a consultant upgrade. These breaches are recorded under different data items (see [DELAY REASON \(CONSULTANT UPGRADE\)](#) and [DELAY REASON COMMENT \(CONSULTANT UPGRADE\)](#)) because the starting point of the upgrade period is different ie date of decision to upgrade rather than receipt of referral.

11.7.11 DELAY REASON COMMENT (REFERRAL TO TREATMENT)

This is the free text comment field to describe why the maximum 62 day period has been breached. It should not include the name of the patient, any other personal details or the clinician(s) involved in the case.

DELAY REASON (CONSULTANT UPGRADE)

This data item enables you to identify from a list of options an overarching reason why (after any adjustments have been removed) a delay/breach occurred to the 62 day consultant upgrade period ie why the health care provider was unable to provide treatment within the service standard of 62 days following a decision to upgrade.

Options - See options for [DELAY REASON \(DECISION TO TREATMENT\)](#)

11.7.12 DELAY REASON COMMENT (CONSULTANT UPGRADE)

This is the free text comment field to describe why the maximum 62 day consultant upgrade period has been breached. It should not include the name of the patient, any other personal details or the clinician(s) involved in the case.

11.8 Other Information

11.8.1 MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR

This records whether the Cancer Care Plan (that was subsequently agreed with the patient) was discussed at a MDT Meeting.

Options

A The patient was discussed at a multidisciplinary team meeting

B The patient was not discussed at a multidisciplinary team meeting.

11.8.2 A patient's case may be discussed at numerous MDT meetings – which one does this data item relate to?

It is the MDT where the care plan that is agreed with the patient is discussed.

11.8.3 What happens if a care plan is drawn up before/after a MDT meeting but is not actually discussed at a MDT - for these patients it will look like they were not discussed at a MDT meeting in the upload; is this correct?

This data item is designed to capture the date of the MDT meeting where the care plan that was agreed was discussed. This may be one of many MDT meetings where an individual case is discussed. By omitting these data from the upload you are not saying the patient was not discussed, only that the agreed care plan was not discussed at a MDT meeting.

11.8.4 MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)

This data item records the date on which the patient was discussed at a multidisciplinary team meeting and a treatment planning decision was made.

12 Glossary of Terms

A&E	Accident and Emergency
BCC	Basal Cell Carcinomas
CAS	Clinical Assessment Services
CIS	Carcinoma in Situ
CWT	Cancer Waiting Times
CWT-Db	Cancer Waiting Times Database
DNA	Did Not Attend
DTT	Decision to Treat
ECAD	Earliest Clinically Appropriate Date
e-RS	e-Referral Service
FDT	First Definitive Treatment
GP	General Practitioner
GDP	General Dental Practitioner
GMP	General Medical Practitioner
GPwSI	General Practitioner with Special Interest
HSCIC	Health and Social Care Information centre
ICD	International Statistical Classification of Disease and Related-Health Problems
IPT	Inter-Provider Transfer
MDT	Multidisciplinary Team
NHS	National Health Service
OPA	Out-patient appointment
PAS	Patient Administration System
PPI	Patient Pathway Identifier
RCR	Royal College of Radiologists
RTDS	Radiotherapy Dataset
RTT	Referral to Treatment
RT	Radiotherapy
SCC	Squamous Cell Carcinoma
SPC	Specialist Palliative Care
SSP	Specialist Screening Practitioner
TCI	To Come In
UBRN	Unique Booking Reference Number
WHO	World Health Organisation